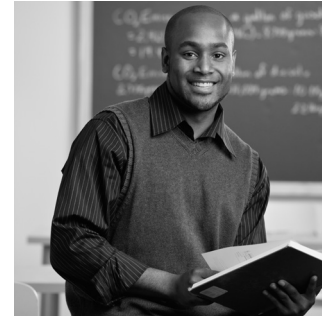


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## RESIDENTIAL CARE AND HOUSING SERVICES

### EXECUTIVE SUMMARY

#### SERVICE INTRODUCTION

##### RESIDENTIAL CARE SERVICES

The landscape of HIV/AIDS residential care services (RCS) has changed over the years. Previously the majority of RCS focused on meeting the needs of people living with HIV/AIDS transitioning from an AIDS diagnosis to end-of-life supportive services. Today, and thanks to continuous advances in early detection, care and treatment, most people living with HIV/AIDS have opportunities to lead long, healthier and productive lives. However, there are still persons living with HIV/AIDS (PLWHA) that need the extra care, supervision and support to carry out activities of daily living (ADL) before transitioning into self-sufficiency.

To address these needs, the Los Angeles County HIV continuum of care includes the following RCS:

- ◆ Transitional residential care facility (TRCF)
- ◆ Residential care facility for the chronically ill (RCFCI)

These services serve as an integral component of Los Angeles County's removal of barriers to HIV/AIDS care efforts by augmenting and supplementing Los Angeles County's existing services for HIV-positive clients who require stable residential care services.

The goals of licensed HIV residential care services for PLWHA are to:

- ◆ Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care or treatment
- ◆ Transition appropriate clients to more permanent, stable housing solutions
- ◆ Provide end-stage care to appropriate clients

##### HOUSING SERVICES

Housing services available to PLWHA and their families in Los Angeles County can include:

- ◆ Hotel/motel and meal vouchers
- ◆ Emergency shelter programs
- ◆ Transitional housing programs
- ◆ Permanent supportive housing programs

The goals of housing services for PLWHA are to:

- ◆ Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care and treatment
- ◆ Transition clients to more permanent, stable housing solutions
- ◆ Assist people living with HIV to remain housed
- ◆ Increase access to employment, mental health and substance abuse services

## SERVICE ORGANIZATIONAL LICENSURE CATEGORY

### LICENSED CATEGORIES

- ◆ **RCFCI:** An RCFCI must be licensed by the Community Care Licensing Division of the California Department of Social Services unless it is exempt from licensure, as specified in regulation.

### UNLICENSED CATEGORIES

- ◆ TRCF – unlicensed service
- ◆ Hotel/motel and meal vouchers – unlicensed service
- ◆ Emergency shelter programs – unlicensed service
- ◆ Transitional housing programs – unlicensed service
- ◆ Permanent supportive housing programs – unlicensed service

## SERVICE CONSIDERATIONS

**General Considerations:** All residential and housing services will be linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid clients in attaining self-sufficiency.

### RESIDENTIAL CARE SERVICES - TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF)

**General Requirements:** TRCFs provide interim housing with ongoing supervision and assistance with independent living skills (ILS) for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management and other supportive services.

**Intake:** The intake determines eligibility and includes demographic data, emergency contact information and eligibility documentation. Upon acceptance of a client into a transitional residential care facility, the person responsible for admissions must interview the prospective client and his/her authorized representative, including the assigned case manager, if any, as soon as reasonably possible.

**Contagious and Infectious Disease Management:** The client must meet the admission requirements of the County of Los Angeles, Department of Public Health's Tuberculosis Control Program.

### Assessment and Education:

- ◆ **Assessment:** At a minimum, each client will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing.
- ◆ **Education:** Upon intake, the facility staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.

**Needs and Services Plan:** Based upon the initial assessment, a needs and services plan will be completed within one week of the client's admission. The needs and services plan will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services.



*Stable  
housing  
is an  
important  
factor in  
health  
outcomes.*

**Housing Services:** Service sites should meet all applicable health and safety regulations issued by the federal, State and/or county governments. Service delivery sites must be safe, clean, alcohol- and drug-free.

**Optional Services:** TRCF may opt to provide an additional array of services to its residents, including, but not limited to:

- ◆ Three balanced meals per day
- ◆ Non-medical case management
- ◆ Individual and group psychotherapy
- ◆ Transportation assistance
- ◆ Ongoing assistance with activity of daily living
- ◆ Educational and/or vocational services
- ◆ Recreational activities

**Referral Services:** Programs providing emergency housing programs will actively collaborate with other agencies to provide referral to the full spectrum of HIV-related services.

**Discharge Planning:** A discharge summary will be completed for each client exiting the program.

**Operation Plan:** Each facility will have and maintain on file a current, written, definitive plan of operation.

**Program Records:** The provider will maintain adequate records on each resident in sufficient detail to permit an evaluation of services.

#### **RESIDENTIAL CARE SERVICES - RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI)**

**General Requirements:** The overriding goal of the RCFCI is to improve the health status of people with HIV/AIDS who need to receive care, support and supervision in a stable living environment to improve their health status before transitioning to self-sufficiency.

**Intake:** Intake is required for all residents who request or who is referred to HIV residential care facilities for the chronically ill. The intake determines eligibility and will include demographic data, emergency contact information, next of kin and eligibility documentation.

**Contagious and Infectious Disease Management:** The resident must meet the admission requirements of the County of Los Angeles Department of Public Health Tuberculosis Control Program.

#### **Assessment and Education:**

- ◆ **Assessment:** Prior to or within 30 days of the acceptance of a resident, the facility will obtain a written medical assessment of the resident which enables the facility to determine if they are able to provide the necessary health-related services required by the resident's medical condition.
- ◆ **Education:** Upon intake, the facility staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities and grievance procedures.

**Individual Services Plan (ISP):** The RCFI will ensure that there is an ISP for each resident. A services plan must be developed for all residents prior to admission based upon the initial assessment.

**Monthly Case Conference:** A monthly case conference will include review of the ISP, including the resident's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate.

**Residential Care Services:** RCFCIs will have written policies, procedures, protocols and a current plan of operations for all services to be provided.

**Medication:** Administration of medication will only be performed by an appropriate skilled professional.

**Support Services:** Support services that are to be provided or coordinated must include, but are not limited to:

- ◆ Provision and oversight of personal and supportive services (assistance with ADL and instrumental ADL)
- ◆ Health related services (e.g., medication management services)
- ◆ Transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Recreational activities
- ◆ Meals
- ◆ Housekeeping and laundry
- ◆ Transportation
- ◆ Provision and/or coordination of all services identified in the ISP
- ◆ Assistance with taking medication
- ◆ Central storing and/or distribution of medications
- ◆ Arrangement of and assistance with medical and dental care
- ◆ Maintenance of house rules for the protection of residents
- ◆ Arrangement and managing of resident schedules and activities
- ◆ Maintenance and/or management of resident cash resources or property

**Recreational Activities:** The facility will ensure that planned recreational activities are provided for the residents. Each resident who is capable will be given an opportunity to participate in the planning, preparation, conducting, clean-up, and critiquing of the activities.

**Volunteer Assistance:** Such services will include, but not be limited to companionship, transportation, respite care, errands and emotional and spiritual support.

**Emergency Medical Treatment:** Residents receiving RCFCI services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility. The cost of such transportation, as well as the cost of emergency medical care, will not be a charge to nor reimbursable under RCFCI services.

**Discharge Planning:** Discharge planning services include, but are not limited to:

RCFCIs will provide discharge planning services to clients that include (at minimum):

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, meals, nutritional support and transportation)
- ◆ Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing and referral
- ◆ Housing such as permanent housing, independent housing, supportive housing, long-term assisted living or other appropriate housing

**Emergency and Disaster Plan:** Programs will have an emergency and disaster plan, describing the procedures and actions to be taken in the event of an emergency, disaster, or disturbance to safeguard residents and facility staff.

**Program Records:** Programs will maintain a separate, complete and current record for each resident in sufficient detail to permit an evaluation of services.

## HOUSING SERVICES

**General Requirements:** HIV housing services provide a variety of emergency, transitional and permanent housing options for people living with HIV. All housing services will be culturally and linguistically appropriate to the target population. In addition, HIV housing services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid clients in attaining self-sufficiency.

## HOTEL/MOTEL AND MEAL VOUCHERS

**General Requirements:** Hotel/motel and meal vouchers are available for a maximum of 30 days per year. To access hotel/motel and meal vouchers, a client must be receiving case management services from a designated referral agency.

**Eligibility Requirements:** To be eligible to receive hotel/motel and meal vouchers a client must:

- ◆ Be diagnosed HIV symptomatic/asymptomatic or AIDS with verifiable documentation
- ◆ Have a state-recognized identification document
- ◆ Be homeless and residing or moving to Los Angeles County
- ◆ Meet current Housing and Urban Development (HUD) income eligibility guidelines and have proof of income if applicable
- ◆ Be working with an authorized referral agency and possess a designated housing plan

**Voucher Requests:** Clients who qualify for hotel/motel and meal vouchers may access this service for no more than 30 days per contract year and in increments of no more than seven days at a time.

**Required Documentation:** The following documents are required to complete the initial hotel/motel and meal voucher process:

- ◆ Client Intake Form – signed by both client and the case manager
- ◆ Case Management Housing Plan/Consent to Release Information – signed by client
- ◆ Rules and Regulations – reviewed by case manager and signed by both the case manager and the client
- ◆ Diagnosis Form
- ◆ Identification for all adults over 18 included on the voucher

## EMERGENCY SHELTER PROGRAMS

**General Requirements:** Each emergency shelter program must adhere to the following general requirements:

- ◆ Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- ◆ Assist with transportation arrangements for clients who do not have independent arrangements
- ◆ Provide ample opportunity for family participation in activities in the facility
- ◆ Include a safety plan to include precautions enacted to protect clients (for those

facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)

- ◆ Develop a disaster plan for implementation during fires, earthquakes, etc.

**Intake:** Client intake is required for all clients who request or are referred to HIV emergency shelter programs. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation.

**Assessment and Education:**

- ◆ **Assessment:** At a minimum, each client will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing.
- ◆ **Education:** Upon intake, the facility staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities and grievance procedures.

**Needs and Services Plan:** Based upon the initial assessment, a needs and services plan that identifies resources for housing and referrals to appropriate medical and social services will be completed for each participant within one week of admission.

**Contagious and Infectious Disease Management:** All clients in emergency shelter programs must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements (<http://lapublichealth.org/tb/index.htm>).

**Housing Services:** Emergency shelter programs will provide the following for their clients (at minimum):

- ◆ Twenty-four hour access to lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol- and drug-free
- ◆ Three balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable)
- ◆ Adequate heating and lighting, plumbing, hot and cold water, toiletries and bathing facilities
- ◆ Accessible telephone in working condition, available for clients to make local phone calls that are job, job-, family- or housing-related
- ◆ Laundry services or facilities

**Referral Services:** Emergency shelter programs will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related services.

**Supportive Services:** Programs providing emergency shelter will provide or coordinate the following services (at minimum):

- ◆ Health-related services (medical care, medication management, adherence, etc.)
- ◆ HIV transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Housekeeping and laundry
- ◆ Transportation

**Discharge Planning:** When feasible, discharge planning services will be provided to clients.

**Program Records:** Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services.



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## TRANSITIONAL HOUSING PROGRAMS

**General Requirements:** Each transitional housing program must adhere to the following general requirements:

- ◆ Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- ◆ Assist with transportation arrangements for clients who do not have independent arrangements
- ◆ Provide ample opportunity for family participation in activities in the facility
- ◆ Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- ◆ Develop a disaster plan for implementation during fires, earthquakes, etc.

**Intake:** Client intake is required for all clients who request or are referred to HIV transitional housing programs. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation.

### **Assessment and Education:**

- ◆ **Assessment:** At a minimum, each client will be assessed identify strengths and gaps in his/her support system as a means to move towards permanent housing.
- ◆ **Education:** Upon intake, the facility staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities and grievance procedures.

**Needs and Services Plan:** Based upon the initial assessment, a needs and services plan that identifies resources for permanent housing and referrals to appropriate medical and social services will be completed for each participant prior to admission.

**Contagious and Infectious Disease Management:** All clients in transitional housing programs must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements (<http://lapublichealth.org/tb/index.htm>).

**Housing Services:** Programs providing transitional housing will provide the following for their clients (at minimum):

- ◆ Twenty-four hour access to lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol- and drug-free
- ◆ Making facilities available to prepare, have delivered or be referred for at three balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable)
- ◆ Adequate heating and lighting, plumbing, hot and cold water, toiletries and bathing facilities
- ◆ Accessible telephone in working condition, available for clients to make local phone calls that are job-, family- or housing-related
- ◆ Laundry services or facilities
- ◆ Self-sufficiency development services (including life-skills training, financial stability planning, etc.), with the ultimate goal of moving recently homeless persons to permanent housing as quickly as possible
- ◆ Supportive services including referrals to case management, medical and social services



**Supportive Services:** Transitional housing programs will provide or coordinate the following services (at minimum):

- ◆ Provision and oversight of personal and supportive services (assistance with ADL living and instrumental ADL)
- ◆ Health-related services (medical care, medication management, adherence, etc.)
- ◆ HIV transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Recreational activities
- ◆ Meals
- ◆ Housekeeping and laundry
- ◆ Transportation

**Referral Services:** Transitional housing programs will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related services.

**Discharge Planning:** When feasible, discharge planning services will be provided to clients.

**Program Records:** Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services.

#### PERMANENT SUPPORTIVE HOUSING PROGRAMS

**General Requirements:** Programs providing permanent housing with supportive services will comply with program requirements of the funding entity. Programs that provide rental subsidies will do so in accordance with guidelines approved by the subsidizing entity.

**Outreach:** Permanent supportive housing programs will conduct outreach activities to potential clients and HIV service providers to promote the availability of and access to HIV permanent supportive housing programs.

**Tenant Selection:** Permanent supportive housing programs will comply with relevant federal, state and local fair housing laws in selecting tenants for housing.

**Intake:** Client intake is required for all clients who request or are referred to HIV permanent supportive housing services. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation.

#### Assessment and Education:

- ◆ **Assessment:** At a minimum, each client will be assessed identify strengths and gaps in his/her support system as a means to move towards permanent housing.
- ◆ **Education:** Upon intake, the facility staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities and grievance procedures.

**Case Management/Supportive Services:** The goal of case management for permanent supportive housing programs is to help clients increase independence and improve decision-making skills.

**Residence Maintenance:** Permanent supportive housing programs will maintain or lease units that meet housing quality standards as outlined in 24 Code of Federal Regulations, Part 574.310(b) (see: <http://www.washingtonwatchdog.org/documents/cfr/title24/part574.html#574.310>).

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**Policies and Procedures Manual:** HIV permanent supportive housing service providers must maintain a policies and procedures manual.

**Landlord Relationships:** Permanent supportive housing programs that provide scattered site master leasing services will act as liaison between the landlord and tenant;

**Discharge Planning:** When requested, discharge planning services will be provided to tenants.

**Resident Eviction:** Permanent supportive housing providers are required to follow state laws and regulations regarding eviction.

**Resident Records:** Providers of permanent supportive housing services will maintain confidential resident records.

## STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all residential care and housing staff will be able to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Residential care and housing staff will complete an agency-based orientation within seven days of being hired that includes client confidentiality and HIPAA regulations. In addition, all new staff must receive HIV/AIDS education within the first three months of employment. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

Direct care staff will be knowledgeable about the HIV disease process and the psychological effects of living with HIV, as well as the co-morbidities of substance abuse and mental illness and their effects on the management of HIV illness. All staff who provide direct-care services and who require licensure must be properly licensed by the state of California. Non-licensed or certified direct care staff will possess appropriate training, experience or certification.

Periodic staff training is required to ensure the continued delivery of quality services. Supervision is required of all staff to provide guidance and support. Direct care staff will be provided with a minimum of one hour's client care-related supervision per month.

Direct care staff will be provided with a minimum of one hour's client care-related supervision per month.



# STANDARDS OF CARE

Los Angeles County Commission on

# HIV

## RESIDENTIAL CARE AND HOUSING SERVICES

### SERVICE INTRODUCTION

#### RESIDENTIAL CARE SERVICES

The landscape of HIV/AIDS residential care services (RCS) has changed over the years. Previously the majority of RCS focused on meeting the needs of people living with HIV/AIDS transitioning from an AIDS diagnosis to end of life supportive services. Today, and thanks to continuous advances in early detection, care and treatment, most people living with HIV/AIDS have opportunities to lead long, healthier and productive lives. However, there are still people living with HIV/AIDS that need the extra care, supervision and support to carry out ADL before transitioning into self-sufficiency.

To address these needs, the Los Angeles County HIV continuum of care includes the following RCS:

- ◆ Transitional residential care facility (TRCF)
- ◆ Residential care facility for the chronically ill (RCFCI)

These services are to serve as an integral component of Los Angeles County's removal of barriers to HIV/AIDS care efforts by augmenting and supplementing Los Angeles County's existing services for HIV-positive clients who require stable residential care services.

The goals of licensed HIV residential care services for people living with HIV are to:

- ◆ Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care or treatment
- ◆ Transition appropriate clients to more permanent, stable housing solutions
- ◆ Provide end-stage care to appropriate clients

#### HOUSING SERVICES

Housing services available to persons living with HIV/AIDS and their families in Los Angeles County can include:

- ◆ Hotel/motel and meal vouchers
- ◆ Emergency shelter programs



*Programs include emergency and transitional housing programs.*

- ◆ Transitional housing programs
- ◆ Permanent supportive housing programs

The goals of housing services for people living with HIV are to:

- ◆ Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care and treatment
- ◆ Transition clients to more permanent, stable housing solutions
- ◆ Assist people living with HIV to remain housed and
- ◆ Increase access to employment, mental health and substance abuse service

Recurring themes in this standard include:

- ◆ Housing services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination and attain and maintain self-sufficiency.
- ◆ Stable housing is critical to accessing and maintaining appropriate medical care and social services.
- ◆ Clients must have a wide array of supportive services available to them as they transition to and remain in stable housing, especially medical care, mental health services and substance abuse treatment.
- ◆ Staff must be appropriately trained, licensed or certified to provide appropriate services.
- ◆ Housing services in this standard must include supportive services of varying degrees and do not include independent living (e.g., Section 8 without services attached to the unit).

The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee clients consistent care, regardless of where they receive services in the County.

All residential care and housing programs will use available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards and California State law regarding confidentiality for information disclosure.

This document represents a synthesis of published standards and research, including:

- ◆ Mercer Report and Rate Study, Office of AIDS Programs and Policy, 2004
- ◆ Achieving Excellence: Standards of Care and Best Practices for HIV/AIDS Supportive Housing, AIDS Housing Corporation, 2004
- ◆ Housing Assistance – Residential Emergency Housing Services, Office of AIDS Programs and Policy
- ◆ Housing Assistance – Residential Transitional Housing Services, Office of AIDS Programs and Policy
- ◆ Housing Assistance – Adult Residential Care Facilities Services, Office of AIDS Programs and Policy
- ◆ Housing Assistance – Residential Care Facilities for the Chronically Ill Services, Office of AIDS Programs and Policy
- ◆ Hotel/Motel and Meal Voucher Program Workshop Booklet, New Image, 2008-2009
- ◆ Standards of care developed by several other Ryan White Plan A Planning Councils. Most valuable in the drafting of this standard were San Antonio (2005), Portland (in press), Baltimore (2004) and Las Vegas.

- ◆ Supportive Services Agreement, City of Los Angeles, Housing Opportunities for Persons with AIDS Program
- ◆ Request for Proposals, City of Los Angeles, Housing Opportunities for Persons with AIDS Program

## SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

### LICENSED CATEGORIES

- ◆ RCFCI: An RCFCI must be licensed by the Community Care Licensing Division of the California Department of Social Services unless it is exempt from licensure, as specified in regulation.

### UNLICENSED CATEGORIES

- ◆ TRCF – unlicensed service
- ◆ Hotel/motel and meal vouchers – unlicensed service
- ◆ Emergency shelter programs – unlicensed service
- ◆ Transitional housing programs – unlicensed service
- ◆ Permanent supportive housing programs – unlicensed service

## DEFINITIONS AND DESCRIPTIONS

**Activities of daily living (ADL)** mean various chores that must be completed by or for a person on a daily basis to meet his/her personal needs. Such chores will include but not be limited to housework, meal preparation, laundry of clothes/linens and other washable items, taking medication, money management, transportation for personal or medical appointments, communicating with others either through telephone or in writing, dressing, eating, toileting, bathing, grooming and ambulation.

**Activity program leader** means a person who meets one of the following: a) has two years of experience in a social or recreational program within the past five years, one year of which was full time in a resident activities program in a health care setting; b) be an occupational therapist, art therapist, music therapist, dance therapist, recreation therapist, or occupational therapist assistant; or c) have satisfactorily completed at least 36 hours of training in a course designed specifically for this position and approved by the State Department of Public Health and will receive regular consultation from an occupational therapist, occupational therapist, or recreation therapist who has at least one year of experience in a health care setting.

**Attending physician** means the physician responsible for the treatment of the resident.

**Care and supervision** means the ongoing assistance with activities of daily living, not to include the endangerment of a resident's physical health, mental health, safety, or welfare.

**Certified nursing assistant or home health aide** means a person who is certified as such by the California State Department of Public Health.

**Congregate housing** is the practice through which a provider develops or leases an entire building with several units for the purpose of housing people living with HIV at affordable costs.

**Direct care staff** means those individuals who are employed by the facility and provide direct care services to the residents including, but not limited to, assistance with ADL.

**HIV/AIDS emergency shelter** provides temporary housing for homeless persons living with HIV disease who require immediate living quarters.

**Homeless** individuals are PLWHA who lack a fixed, regular and adequate residence; lack the financial resources to acquire shelter; or reside in 1) a shelter to provide temporary, emergency accommodation; 2) an institution that provides temporary residence or care for individuals; or 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

**Hospice nurse** means a registered nurse (RN) who has acute care experience and training and experience in the delivery of nursing care to the terminally ill who have accepted the hospice concept.

**Licensed vocational nurse (LVN)** means a person licensed as such by the California of Vocational Nurse and Psychiatric Technician Examiners.

**Medical professional** means an individual licensed or certified in California to perform the necessary medical procedures within the scope of his/her practice. This includes, but is limited to, medical doctor (MD), RN and LVN.

**Nutritionist** means a person who has a Master's degree in food and nutrition, dietetics, or public health nutrition.

**Occupational therapist** means a person who is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and is registered by the American Occupational Therapy Association.

**Permanent supportive housing** is affordable permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and service needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. Permanent supportive housing can be provided either in a congregate housing facility or through scattered site master leasing.

**Pharmacist** means a person licensed as such by the California Board of Pharmacy.

**Physical therapist** means a person licensed as such by the Physical Therapy Examining Committee of the California Board of Medical Quality Assurance.

**Physician** means a person licensed as a physician and surgeon by the California Board of Medical Quality Assurance or by the California Board of Osteopathic Examiners.

**Registered nurse (RN)** means a person licensed as such in the State California by the Board of Registered Nursing.



**Residential care facility for the chronically ill (RCFCI)** is any housing arrangement maintained and operated to provide care and supervision to adults, emancipated minors or family units living with HIV. An RCFCI may not exceed 50 beds.

**Respiratory therapist** means a person with a California State respiratory Care Practitioner's Certificated issued by the Respiratory Care Examining Committee, and has: a one year's experience at the level of a Respiratory Therapy Technician; b) an associate degree in respiratory therapy from an accredited college; or c) a certificate of completion from an approved two-year training program in respiratory therapy.

**Scattered site master leasing** is the practice through which an organization leases rental units throughout the county that are then sub-leased at affordable costs to people living with HIV.

**Social worker** means a person who has a Master of Social Work degree from a school of social work accredited or approved by the Council on Social Work Education and has one year of social work experience in a health care setting.

**Social worker assistance** means a person with a baccalaureate degree in the social sciences or related fields from an accredited college or university and has had a least one year of social work experience in a health care setting.

**Speech pathologist** means a person licensed as such by the California Board of Medical Quality Assurance.

**SSI/SSP** means Supplemental Security Income / State Supplemental Program which is a federal/state program that provides financial assistance to the aged, blind and/or disabled residents of California.

**Transitional housing** is housing for up to twenty-four months for homeless persons living with HIV and their families. The purpose of this service is to facilitate movement towards more traditional and permanent housing through self-sufficiency activities such as counseling, case management and other supportive services.

## HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California. (Epidemiologic Profile of HIV in Los Angeles County, 2013).

For PLWHA, housing is one of the strongest predictors of treatment access and health outcomes<sup>1</sup> — allowing PLWHA to access comprehensive healthcare and adhere to complex HIV/AIDS drug therapies.<sup>2</sup> New research findings demonstrate the direct relationship between inadequate housing and greater risk of HIV infection, poor health outcomes and early death.<sup>3</sup> Rates of new HIV diagnoses among populations of homeless persons are as much as sixteen times the rate in the general population and death rates due to HIV/AIDS are five to seven times higher among homeless persons.<sup>4</sup> Homeless and unstably housed persons are two to six times more likely to use hard drugs, share needles or exchange sex than similar persons with stable housing, as the lack of stable housing directly impacts the ability of people living in poverty to reduce HIV risk behaviors.<sup>5</sup> Compared to stably housed PLWHA, homeless PLWHA rate their mental, physical and overall health worse, and are



more likely to be uninsured, use an emergency room and be admitted to a hospital.<sup>6</sup>

By comparison, PLWHA who receive any level of housing assistance are almost four times as likely to enter into medical care<sup>7</sup> and six times more likely to receive HAART.<sup>8</sup> Each prevented HIV infection saves more than \$300,000 in lifetime medical costs.<sup>9</sup>

The burden of HIV/AIDS is multiplied by the enormous number of HIV-infected people, co-morbid diseases, the extremely high numbers of people in poverty and without health insurance and the challenges of providing services across 4,084 square miles to individuals who are already disenfranchised.<sup>10</sup> With no way to refrigerate medications, prepare healthy meals or access regular medical care, homeless PLWHA have little hope of following treatment regimens or sustaining their health.

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<sup>1</sup> Kidder, Wolitski, Pals, Campsmith, "Housing Status and HIV Risk Behaviors Among Homeless and Housed Persons With HIV," Journal of Acquired Immune Deficiency Syndromes, 2008<sup>2</sup> Hud.gov<sup>3</sup> Endorsement of HIV/AIDS Housing Resolution (S.Con.Res 102), introduced by Sen. H. Clinton, 2008<sup>4</sup> National AIDS Housing Coalition (NAHC): "Housing is HIV Prevention and Health Care – Findings from Nat'l. Housing and HIV/AIDS Research Summit," 2008. <sup>5</sup> Clinton et al. 2008. <sup>6</sup> Kidder, Wolitski, Campsmith, G.V. Nakamura. Health status, health care use, medication use, and medication adherence in homeless and housed people living with HIV/AIDS. American Journal of Public Health, 2007. <sup>7</sup> Aidala, Waddell, Sotheran, "Delayers, Drop-outs, the Unconnected, and Unmet Need," Community Health Advisory, Columbia Univ., Mailman School of Public Health, 2005. <sup>8</sup> Aidala, Cross, Stall, Harre, Sumartojo, "Housing status and HIV risk behaviors: Implications for prevention and policy," AIDS and Behavior, 2005. <sup>9</sup> Schackman, Freedberg, Gebo, Moore, "Lifetime Cost And Life Expectancy For Current HIV Care In The U.S.," Medical Care, 2006 <sup>10</sup> L.A. County Dept. of Public Health, ibid.

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## SERVICE COMPONENTS

### RESIDENTIAL CARE SERVICES – TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF)

#### GENERAL REQUIREMENTS – TRCF

TRCFs provide interim housing with ongoing supervision and assistance with ILS for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management and other supportive services.

Prospective recipients of TRCF services must meet each of the following criteria:

- ◆ Be 18 years of age or older
- ◆ Have an HIV/AIDS diagnosis from a primary care physician
- ◆ Have a Karnofsky score of 70 or higher
- ◆ Be certified by a qualified a qualified mental health professional to have a score on the Global Assessment of Functioning (GAF) of 65 or less
- ◆ Be actively engaged / receiving medical care
- ◆ Be certified by their medical care providers to be taking prescription medications independently
- ◆ Be homeless

Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, Providers must develop criteria and procedures to determine client eligibility and to ensure

that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

Providers may charge up to 30% of residents' income to cover program costs not covered by the contracting agency. The provider will comply with provisions of Section 2605 (e) of Title 26 (CARE Act) which is entitled "Requirements Regarding Imposition of Charges for Services." Providers will be responsible for developing and implementing a resident fee system. The provider will pursue funding from public assistance and entitlement programs for which each County responsible resident may be eligible.

STANDARD	MEASURE
TRCFs may accept clients who meet each of the following criteria: <ul style="list-style-type: none"> <li>• Be 18 years of age or older</li> <li>• Have an HIV/AIDS diagnosis from a primary care physician</li> <li>• Have a Karnofsky score of 70 or higher</li> <li>• Be certified by a qualified a qualified mental health professional to have a score on the GAF of 65 or less</li> <li>• Be actively engaged / receiving medical care</li> <li>• Be certified by their medical care providers to be take prescription medications independently</li> <li>• Be homeless</li> </ul>	Program review and monitoring to confirm.
Programs must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available.	Program review and monitoring to confirm.
Providers may charge up to 30% of residents' income to cover program costs not covered by the contracting agency.	Program review and monitoring to confirm.

#### INTAKE – TRCF

The intake determines eligibility and includes demographic data, emergency contact information and eligibility documentation. Upon acceptance of a client into a TRCF, the person responsible for admissions must interview the prospective client and his/her authorized representative, including the assigned case manager, if any, as soon as reasonably possible.

As part of the intake process, the client file will include the following information (at minimum):

- ◆ Proof of HIV diagnosis
- ◆ Proof of income
- ◆ Proof of residence in Los Angeles County

**Required Forms:** Programs must develop the following documents in accordance with State and local guidelines.

Completed forms are required for each client and will be maintained in each client record:

- ◆ Release of Information (must be updated annually)
- ◆ Consent to Receive Services
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Client Rights and Responsibilities
- ◆ Client Grievance Procedures

STANDARD	MEASURE
Prospective client interviewed upon acceptance in TRCF.	Intake tool is completed and in client file.
Eligibility for services is determined.	Client's file includes: <ul style="list-style-type: none"> <li>• Proof of HIV diagnosis</li> <li>• Proof of income</li> <li>• Proof of Los Angeles County residence</li> </ul>
Consent to Receive Services and Release of Information is discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Client is informed of Confidentiality Policy, Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

### CONTAGIOUS AND INFECTIOUS DISEASE MANAGEMENT – TRCF

The client must meet the admission requirements of the County of Los Angeles, Department of Public Health's Tuberculosis Control Program. The nature of residential care may preclude having important information prior to admission of the client. However, the client must be observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client will be isolated and a physician will be consulted to determine suitability of the client's retention in the program.

STANDARD	MEASURE
Clients must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements.	Program review and monitoring to confirm.
Clients exhibiting symptoms of infectious or contagious disease will be isolated until a physician is consulted.	Record of isolation and physician consult on file in client chart.

### ASSESSMENT AND EDUCATION – EMERGENCY HOUSING PROGRAMS

#### ASSESSMENT

At a minimum, each client will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing.

Assessments will include the following:

- ◆ Age
- ◆ Health status
- ◆ Family involvement
- ◆ Family composition
- ◆ Special housing needs
- ◆ Level of independence
- ◆ Income
- ◆ Public entitlements
- ◆ Substance abuse history
- ◆ Mental health status and history
- ◆ Credit history
- ◆ History of evictions
- ◆ Level of resources available to solve problems
- ◆ Co-morbidity factors

Residents receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards

self-sufficiency with ILS. TRCF residents will be expected to transition towards independent living or another type of residential service more suitable to his/her needs.

### EDUCATION

Upon intake, the facility will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures. Further, resident education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, tuberculosis (TB), important health and self-care practices, and information about referral agencies that are supportive of people living with HIV/AIDS.

STANDARD	MEASURE
<p>Clients will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing. Assessments will include the following:</p> <ul style="list-style-type: none"> <li>• Age</li> <li>• Health status</li> <li>• Family involvement</li> <li>• Family composition</li> <li>• Special housing needs</li> <li>• Level of independence</li> <li>• ADLs</li> <li>• Income</li> <li>• Public entitlements</li> <li>• Substance abuse</li> <li>• Mental health</li> <li>• Credit history</li> <li>• History of evictions</li> <li>• Level of resources available to solve problems</li> <li>• Co-morbidity factors</li> </ul>	Signed, dated assessment on file in client chart.
Residents receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ILS.	Signed, dated assessment on file in client chart.
Staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.	Documentation of client education on file at provider agency.

### NEEDS AND SERVICES PLAN – TRCF

Based upon the initial assessment, a needs and services plan will be completed within one week of the client's admission. The needs and services plan will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services. Plans will also include specialized services needed to maintain the client in housing and access and adherence to primary medical care services. Documentation within the needs and services plan will include the identified goals, steps to achieve the goals, expected timeframe in which to complete the goals, and the disposition of each goal.

STANDARD	MEASURE
Needs and services plan will be completed prior to admission.	Needs and services plan on file in client chart signed by client detailing a housing resources and medical and social service referrals made.



*Supportive  
services  
include  
food and  
nutrition.*

## HOUSING SERVICES – TRCF

Service sites should meet all applicable health and safety regulations issued by the federal, State, and/or county governments. Service delivery sites must be safe, clean, alcohol- and drug-free. The provider will request approval from DHSP in writing a minimum of 30 days before terminating services at such location(s) and/or before commencing services at any other location(s).

At a minimum, TRCF services must include:

- ◆ Twenty-four hour access to a lodging in a secured home-like facility that is clean, safe, comfortable, and alcohol- and drug-free
- ◆ Onsite, overnight supervision from 4:00 p.m. to 8:00 a.m. the following day
- ◆ Facilities for residents to prepare and have at least three balanced meals per day, or referrals to three balanced meals per day (referrals to missions or soup kitchens are not acceptable alternatives)
- ◆ A living environment with adequate heating and lighting, hot and cold water, toiletries, and full bathroom facilities
- ◆ Individual beds and clean bed linens at least every seven days, or as needed
- ◆ Individual, secured storage space for residents to keep and access their medications
- ◆ Access to a telephone in working order for residents to make local phone calls that are health, job-, family- or housing related
- ◆ Laundry services or facilities on the premises
- ◆ Activities to develop residents' self-sufficiency / ILS including seeking and receiving needed services, and managing financial and other personal resources—with the ultimate goal of moving residents towards independent living
- ◆ Occasional assistance with ADL, not to extend for a period of more than three months, for residents who experience a temporary set-back in their health status as reflected by a Karnofsky score of less than 70
- ◆ Linkage to services such as case management, medical care, benefits determination, transportation assistance, housing, vocational development or employment placement, and other social services

Residents receiving DHSP-funded TRCF services will have a maximum stay of 24 months. DHSP approval will be required for monthly extensions based on the residents' overall level of functioning. A client's bed may be held by a provider for no more than two one-night "bed-holds" per client per quarter in medical emergencies or for therapeutic reasons, as long as this is clearly documented in the client's chart and/or treatment plan.

STANDARD	MEASURE
<p>At a minimum, TRCF services must include:</p> <ul style="list-style-type: none"> <li>• 24-hour access to a lodging in a secured home-like facility that is clean, safe, comfortable, and alcohol- and drug-free</li> <li>• Onsite, overnight supervision from 4:00 p.m. to 8:00 a.m. the following day</li> <li>• Facilities for residents to prepare and have at least three balanced meals per day, or referrals to three balanced meals per day (referrals to missions or soup kitchens are not acceptable alternatives)</li> <li>• A living environment with adequate heating and lighting, hot and cold water, toiletries, and full bathroom facilities</li> <li>• Individual beds and clean bed linens at least every seven days, or as needed</li> <li>• Individual, secured storage space for residents to keep and access their medications</li> <li>• Access to a telephone in working order for residents to make local phone calls that are health, job-, family- or housing-related</li> <li>• Laundry services or facilities on the premises</li> <li>• Activities to develop residents' self-sufficiency / ILS including seeking and receiving needed services, managing financial and other personal resources; with the ultimate goal of moving residents towards independent living</li> <li>• Occasional assistance with ADL, not to extend for a period of more than three months, for residents who experience a temporary set-back in their health status as reflected by a Karnofsky score of less than 70</li> <li>• Linkage to services such as case management, medical care, benefits determination, transportation assistance, housing, vocational development or employment placement, and other social services</li> </ul>	<p>Program review and monitoring to confirm.</p>
<p>Maximum stay in TRCF is 24 months with monthly extensions based on overall level of client functioning.</p>	<p>Program review and monitoring to confirm.</p>

### OPTIONAL SERVICES – TRCF

TRCF may opt to provide an additional array of services to its residents, including, but not limited to:

- ◆ Three balanced meals per day
- ◆ Non-medical case management
- ◆ Individual and group psychotherapy
- ◆ Transportation assistance
- ◆ Ongoing assistance with activity of daily living
- ◆ Educational and/or vocational services
- ◆ Recreational activities

These services will be provided solely at the discretion of the service provider, are not part of the reimbursement fee for TRCF, and cannot be billed to DHSP as part of a TRCF contract. TRCFs providing any or all of these services should indicate whether these services are provided directly by the provider or through a third-party agreement licensed to provide the proposed services. TRCFs directly delivering any of the optional services described above should also indicate the revenue stream supporting service delivery, including income from client fees.

Clients receiving services hereunder who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility. The cost

of such transportation as well as the cost of emergency medical care will not be a charge to nor reimbursable hereunder. The provider will have a written agreement(s) with a licensed medical facility(ies) within the community for provision of emergency services as appropriate. Copy(ies) of such written agreement(s) will be sent to County's Department of Public Health, DHSP, Clinical Enhancement Services Division.

STANDARD	MEASURE
TRCFs may provide at own expense additional services including, but not limited to: <ul style="list-style-type: none"> <li>• Three balanced meals per day</li> <li>• Non-medical case management</li> <li>• Individual and group psychotherapy</li> <li>• Transportation assistance</li> <li>• Ongoing assistance with activity of daily living</li> <li>• Educational and/or vocational services</li> <li>• Recreational activities</li> </ul>	Program review and monitoring to confirm that not billed to DHSP.
Clients receiving TRCF services who require emergency medical treatment will be transported to an appropriate medical facility at TRCF's own expense.	Program review to confirm that not billed to DHSP.

#### REFERRAL SERVICES – TRCF

Programs will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related services.

Programs will maintain a comprehensive list of target providers and will refer and link clients to services consistent with their needs, including, but not limited to:

- ◆ Medical care
- ◆ Mental health treatment
- ◆ Substance abuse treatment
- ◆ Case management
- ◆ Peer support
- ◆ Vocational training
- ◆ Education
- ◆ Treatment education
- ◆ Dental treatment
- ◆ Legal and financial services

Further, programs will make available to clients information about public health, social services and where to apply for State, federal and/or county entitlement programs.

STANDARD	MEASURE
Programs will demonstrate active collaboration with providers of full spectrum of HIV-related services.	Memoranda of Understanding on file at provider agency.
Programs must maintain a list of target providers to full spectrum of HIV-related services.	Referral list on file at provider agency.



STANDARD	MEASURE
<p>Programs will refer and link clients to services including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Medical care</li> <li>• Mental health treatment</li> <li>• Substance abuse treatment</li> <li>• Case management</li> <li>• Peer support</li> <li>• Vocational training</li> <li>• Education</li> <li>• Treatment education</li> <li>• Dental treatment</li> <li>• Legal and financial services</li> </ul>	<p>Signed, dated progress notes on files in client chart to detail referrals and linkages.</p>

### DISCHARGE PLANNING – TRCF

A discharge summary will be completed for each client exiting the program.

A discharge summary will include, but not be limited to:

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, nutritional support and transportation)
- ◆ Early intervention services to link people living with HIV into care, including outreach, HIV counseling and testing, and referral
- ◆ Housing such as permanent housing, independent housing, supportive housing, or other available housing

Clients will be offered the opportunity to participate in the discharge planning process and will receive a copy of the plan, including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time.

STANDARD	MEASURE
<p>A discharge summary will be completed for each client exiting the program and will include, but not be limited to:</p> <ul style="list-style-type: none"> <li>• Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate</li> <li>• Linkage to supportive services that enhance access to care (e.g., case management, nutritional support and transportation)</li> <li>• Early intervention services to link people living with HIV into care, including outreach, HIV counseling and testing, and referral</li> <li>• Housing such as permanent housing, independent housing, supportive housing, or other available housing</li> </ul>	<p>Discharge summary on file in client chart.</p>
<p>Clients will have opportunity to participate in discharge planning process and receive a copy of the plan.</p>	<p>Documentation of client involvement in discharge planning and receipt of copy of plan.</p>

### OPERATION PLAN – TRCF

Each facility will have and maintain on file a current, written, definitive plan of operation outlining the following:

- ◆ Admission/discharge policies and procedures (including admission requirements)
- ◆ Admission agreements
- ◆ Residents' rights and responsibilities, including code of conduct
- ◆ Service planning and delivery

- ◆ Staffing plan, including qualifications and duties of staff
- ◆ In-service education of staff
- ◆ Emergency procedures

If the facility intends to admit and/or specialize in care for one or more clients who have a propensity for behaviors that result in harm to self or others, the plan of operation will include a description of precautions that will be taken to protect that client and all other clients.

STANDARD	MEASURE
<p>Programs will have a current, written, definitive plan of operation outlining the following:</p> <ul style="list-style-type: none"> <li>• Admission/discharge policies and procedures (including admission requirements)</li> <li>• Admission agreements</li> <li>• Residents' rights and responsibilities, including code of conduct</li> <li>• Service planning and delivery</li> <li>• Staffing plan, including qualifications and duties of staff</li> <li>• In-service education of staff</li> <li>• Emergency procedures</li> </ul>	<p>Operation plan on file at provider agency.</p>

#### PROGRAM RECORDS – TRCF

The provider will maintain adequate records on each resident in sufficient detail to permit an evaluation of services.

The information will include, but not be limited to:

- ◆ Documentation of resident's diagnosis of HIV/AIDS
- ◆ Housing status prior to admission
- ◆ Certification in writing by a physician or other duly authorized health care professional that the resident is free from active TB (mycobacterium TB)
- ◆ Written agreement signed by resident describing terms and conditions of tenancy and residents' rights
- ◆ Resident data including dates of admission and discharge, and emergency notification information
- ◆ Documentation of case management services provided including assessment of resident's needs, assistance with goal development and traditional housing plan, and weekly progress toward accomplishment of goals/plan
- ◆ Name of case management agency with which resident is enrolled and/or documentation of referral to such an agency having expertise in providing case management services
- ◆ Documentation of provision of drug or alcohol abuse counseling or referral for such
- ◆ Documentation of occupancy

STANDARD	MEASURE
<p>Programs will maintain adequate records on each client to permit evaluation of services including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Documentation of resident's diagnosis of HIV/AIDS</li> <li>• Housing status prior to admission</li> <li>• Certification in writing by a physician or other duly authorized health care professional that the resident is free from active TB (mycobacterium TB)</li> <li>• Written agreement signed by resident describing terms and conditions of tenancy and residents' rights</li> <li>• Resident data including dates of admission and discharge, and emergency notification information</li> <li>• Documentation of case management services provided including assessment of resident's needs, assistance with goal development and traditional housing plan, and weekly progress toward accomplishment of goals/plan</li> <li>• Name of case management agency with which resident is enrolled and/or documentation of referral to such an agency having expertise in providing case management services</li> <li>• Documentation of provision of drug or alcohol abuse counseling or referral for such</li> <li>• Documentation of occupancy</li> </ul>	<p>Record of documentation on file in client chart.</p>

## RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI)

### GENERAL REQUIREMENTS – RCFCI

The overriding goal of the RCFCI is to improve the health status of people with HIV/AIDS who need to receive care, support and supervision in a stable living environment to improve their health status before transitioning to self-sufficiency.

RCFCIs are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, homelike environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision to any of the following:

- ♦ Adults 18 years of age or older with living HIV/AIDS;
- ♦ Emancipated minors living with HIV/AIDS; or
- ♦ Family units with adults or children, or both, living with HIV/AIDS.

The capacity of a RCFCI may not exceed 50 beds. In addition to meeting eligibility requirements outlined in Title 22, prospective recipients of RCFCI services must meet each of the following criteria:

- ♦ Have an AIDS diagnosis from a primary care physician
- ♦ Be certified by a qualified a qualified health care professional to need regular or ongoing assistance with ADL
- ♦ Have a Karnofsky score of 70 or less
- ♦ Have an unstable living situation
- ♦ Be a resident of Los Angeles County

Furthermore, and with the exception of those with conditions specified in regulation, an RCFCI may accept or retain the following residents whose condition has been diagnosed as chronic and life threatening and who require different levels of care:

- ♦ Residents whose illness is intensifying and causing deterioration in their condition, provided they do not require impatient care in an acute care hospital or a skilled nursing facility, as determined by the resident's physician

- ◆ Residents whose condition has deteriorated to a point where death is imminent
- ◆ Residents who have, in the addition to the above, other medical conditions or needs or require the use of medical equipment, as long as the facility is able to meet statutory regulation requirements when providing services to these residents.

The facility will not accept or retain a resident who:

- ◆ Requires in-patient care in an acute hospital
- ◆ Requires treatment and/or observation by the appropriately skilled professional for more than eight hours per day in the facility
- ◆ Has communicable TB or any reportable disease (except HIV/AIDS)
- ◆ Requires 24-hour intravenous therapy
- ◆ Has a psychiatric condition(s) and is exhibiting behaviors which could present a danger to self or others
- ◆ Has a Stage II or greater decubitus ulcer
- ◆ Requires renal dialysis treatment in the facility
- ◆ Requires life support systems including, not limited to, ventilators and Respirators
- ◆ Has a diagnosis that does not include a chronic life-threatening illness
- ◆ Has primary diagnosis of Alzheimer's
- ◆ Has a primary diagnosis of Parkinson's disease

Residents receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for monthly extensions beyond 24 months based on the resident's health status. A resident's bed may be held by a provider for no more than eight one-night "bed-holds" per resident per quarter in medical emergencies or for therapeutic reasons, as long as this is clearly documented in the resident's chart and/or treatment plan.

RCFCI providers will develop criteria and procedures to determine resident eligibility to ensure that no other options for residential services are available. RCFCI providers must document resident eligibility and must further demonstrate that third-party reimbursement (e.g., medical) is being actively pursued, where applicable.

Providers of RCFCI services may charge up to 30% of the income of adult family members who are not the primary service recipient in the family unit to help cover the costs of providing services not covered by the RCFCI contract.

RCFCI providers will develop and implement a resident sliding scale fee plan for those residents who could be charged for services as outlined below:

- ◆ For SSI/SSP recipients who are residents, the basic services will be provided and/or made available at the basic rate with no additional charge to the resident. This will not preclude the acceptance by the facility of voluntary contributions from relatives on behalf of an SSI/SSP recipient.
- ◆ An extra charge to resident will be allowed for a private room upon the resident's request (and if such room is available). If a double room is available but the resident prefers a private room, it must be documented in the admission agreement and charge is limited to 10% of the board and room portion of the SSI/SSP grant.
- ◆ The extra charge to the resident will be allowed for special food services or products beyond that specified above when the resident wishes to purchase the services and agree to the extra charge in the admission agreement.

Detailed information about Title 22 licensing requirements for RCFCI can be found at <http://www.dss.cahwnet.gov/ord/PG295.htm>.

STANDARD	MEASURE
<p>RCFCIs are licensed to provide 24-hour care and supervision to any of the following:</p> <ul style="list-style-type: none"> <li>Adults 18 years of age or older with living HIV/AIDS</li> <li>Emancipated minors living with HIV/AIDS</li> <li>Family units with adults or children, or both, living with HIV/AIDS</li> </ul>	<p>Program review and monitoring to confirm.</p>
<p>RCFCIs may accept clients that meet each of the following criteria:</p> <ul style="list-style-type: none"> <li>Have an AIDS diagnosis from a primary care physician</li> <li>Be certified by a qualified health care professional to need regular or ongoing assistance with ADL</li> <li>Have a Karnofsky score of 70 or less</li> <li>Have an unstable living situation</li> <li>Be a resident of Los Angeles County resident</li> </ul>	<p>Program review and monitoring to confirm.</p>
<p>RCFCIs may accept clients with chronic and life threatening diagnoses requiring different levels of care, including:</p> <ul style="list-style-type: none"> <li>Clients whose illness is intensifying and causing deterioration in their condition</li> <li>Clients whose conditions have deteriorated to a point where death is imminent</li> <li>Clients who have other medical conditions or needs, or require the use of medical equipment that the facility can provide</li> </ul>	<p>Program review and monitoring to confirm.</p>
<p>RCFCIs will not accept or retain clients who:</p> <ul style="list-style-type: none"> <li>Require inpatient care</li> <li>Require treatment and/or observation for more than eight hours per day</li> <li>Have communicable TB or any reportable disease</li> <li>Require 24-hour intravenous therapy</li> <li>Have dangerous psychiatric conditions</li> <li>Have a Stage II or greater decubitus ulcer</li> <li>Require renal dialysis in the facility</li> <li>Require life support systems</li> <li>Do not have chronic life-threatening illness</li> <li>Have a primary diagnosis of Alzheimer's</li> <li>Have a primary diagnosis of Parkinson's disease</li> </ul>	<p>Program review and monitoring to confirm.</p>
<p>Maximum length of stay is 24 months with monthly extensions bases on resident's health status.</p>	<p>Program review and monitoring to confirm.</p>
<p>RCFCI will develop criteria and procedures to determine resident eligibility to ensure that no other options for residential services are available.</p>	<p>Program review and monitoring to confirm.</p>
<p>Programs may charge up to 30% of the income of adult family members who are not the primary service recipient to help cover the costs of providing services not covered by the RCFCI contract. Sliding scale fee plan as follows:</p> <ul style="list-style-type: none"> <li>For SSI/SSP recipients who are residents, the basic services will be provided and/or made available at the basic rate with no additional charge to the resident. This will not preclude the acceptance by the facility of voluntary contributions from relatives on behalf of an SSI/SSP recipient.</li> <li>An extra charge to resident will be allowed for a private room upon the resident's request (and if such room is available). If a double room is available but the resident prefers a private room, it must be documented in the admission agreement and charge is limited to 10% of the board and room portion of the SSI/SSP grant.</li> <li>The extra charge to the resident will be allowed for special food services or products beyond that specified above when the resident wishes to purchase the services and agree to the extra charge in the admission agreement.</li> </ul>	<p>Program review and monitoring to confirm.</p>

## INTAKE – RCFCI

Intake is required for all residents who request or who is referred to HIV residential care facilities for the chronically ill. The intake determines eligibility and will include demographic data, emergency contact information, next of kin and eligibility documentation.

In the intake process and throughout the HIV residential care facility for the chronically ill service delivery, resident confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality.

As needed, Release of Information forms will be gathered. These forms will contain detailed specific person(s) or agencies to which the information will be released as well as the specific kind of information to be released. New forms will be added for individuals not listed on the most current Release of Information. Specification will indicate the type of information that can be released.

As part of the intake process, the client file will include the following information (at minimum):

- ◆ Proof of HIV diagnosis
- ◆ Proof of ongoing need with ADL (medical provider's letter, completed Karnofsky)
- ◆ Proof of income
- ◆ Proof of residence in Los Angeles County

**Required Forms:** Programs must develop the following forms in accordance with State, local guidelines and must be completed for each resident:

- ◆ Release of Information
- ◆ Consent to Receive Services
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Resident's Rights and Responsibilities
- ◆ Resident's Grievance Procedures

Prior to accepting a resident into residential care facilities for the chronically ill, the person responsible for admissions must interview the prospective resident and/or his/her authorized representative, including the assigned case manager, if any, to document the intake and assessment findings.

Persons eligible for residential care facilities for the chronically ill must have HIV/AIDS disease and are in need of housing, care and supervision. At minimum, determination of eligibility should be based on housing status and financial eligibility and must meet the conditions described above. AIDS status should be documented during the intake process.

STANDARD	MEASURE
<p>Programs must develop the following forms in accordance with State, local guidelines and must be completed for each resident:</p> <ul style="list-style-type: none"> <li>• Release of Information</li> <li>• Consent to Receive Services</li> <li>• Limits of Confidentiality (Confidentiality Policy)</li> <li>• Resident's Rights and Responsibilities</li> <li>• Resident's Grievance Procedures</li> </ul>	<p>Signed and dated forms on file in client chart.</p>

STANDARD	MEASURE
Eligibility for services is determined.	Client's file includes: <ul style="list-style-type: none"> <li>• Proof of AIDS diagnosis</li> <li>• Proof of ongoing need with ADL (medical provider's letter, completed Karnofsky)</li> <li>• Proof of income</li> <li>• Proof of Los Angeles County residence</li> </ul>
Prior to acceptance into program, prospective resident and his/her authorized representative must be interviewed to document intake and assessment findings.	Record of interview on file in client chart.

### CONTAGIOUS AND INFECTIOUS DISEASE MANAGEMENT – RCFCI

The resident must meet the admission requirements of the County of Los Angeles Department of Public Health Tuberculosis Control Program. Residents should be regularly observed and questioned about health status and symptoms that may indicate that the resident has a contagious or infectious disease (other than AIDS). If a resident is suspected of having a contagious or infectious disease, the resident should be isolated and a physician should be consulted to determine suitability of the resident's retention in the program.

The provider will ensure that a current log is maintained for all residents which includes the dates and results of Mantoux tuberculin skin tests measured in millimeters, chest X-rays, and the physician statements verifying that each resident does not have communicable TB.

STANDARD	MEASURE
Clients must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements.	Program review and monitoring to confirm.
Clients exhibiting symptoms of infectious or contagious disease will be isolated until a physician is consulted.	Record of isolation and physician consult on file in client chart.
Programs must maintain current log for all residents of dates and results of Mantoux tuberculin skin tests and physician statements verifying that resident does not have communicable TB.	Current log on file at provider agency.

### ASSESSMENT AND EDUCATION – RCFCI

#### ASSESSMENT

Prior to or within 30 days of the acceptance of a resident, the facility will obtain a written medical assessment of the resident which enables the facility to determine if they are able to provide the necessary health-related services required by the resident's medical condition. Such assessment will be performed by, or under the supervision of, a licensed physician and should not be more than three months old when obtained. If the assessment is not completed prior to admission of the resident, an RN must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present which may preclude placement.

Areas for assessment include need for palliative care, age, health status, including HIV prevention needs, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level and resources available to solve problems, and co-morbidity factors.



The medical assessment will provide a record of any infectious or contagious disease which would preclude care of the person. A chest X-ray which was obtained not more than three months prior to placement or a Mantoux tuberculin skin test recorded in a millimeter which was performed not more than three months prior to placement. A person who has had a previous positive reaction should not be required to obtain a Mantoux tuberculin skin test, but will be required to obtain chest X-ray results and a physician's statement that he/she does not have communicable TB.

If the facility provides services for residents with mental illness, a written intake assessment is completed by a licensed mental health professional prior to acceptance of the resident. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional. Facility administrators may use placement agencies, including, but not limited to, County clinics for referrals and assessments.

Residents receiving DHSP-funded RCFCI services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

If it is determined that the person requires immediate health care, and needs cannot be met by the RCFCI, the provider will ensure that the person is referred to the appropriate health facility and that the medical assessment is performed.

### **EDUCATION**

If a prospective resident is deemed eligible for intake, the facility staff will provide the resident with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, resident rights and responsibilities, and grievance procedures. Further, resident and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.

STANDARD	MEASURE
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance. If not completed prior to client admission, an RN must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present that may preclude placement.	Signed, dated medical assessment on file in client chart.
Assessments will include the following: <ul style="list-style-type: none"> <li>• Need for palliative care</li> <li>• Age</li> <li>• Health status, including HIV prevention needs</li> <li>• Record of medications and prescriptions</li> <li>• Ambulatory status</li> <li>• Family composition</li> <li>• Special housing needs</li> <li>• Level of independence</li> <li>• Level of resources available to solve problems</li> <li>• Co-morbidity factors</li> </ul>	Signed, dated assessment on file in client chart.

STANDARD	MEASURE
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance. If not completed prior to client admission, an RN must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present that may preclude placement.	Signed, dated medical assessment on file in client chart.
The medical assessment will provide a record of any infectious or contagious disease precluding care.	Signed, dated medical assessment on file in client chart.
If the facility provides services for residents with mental illness, a written intake assessment is completed by a licensed mental health professional prior to acceptance of the resident. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional.	Signed, dated mental health assessment on file in client chart.
Residents must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of reassessment on file in client chart.
If a RCFCI cannot meet a client's needs a referral must be made to an appropriate health facility.	Documentation of referrals on file at provider agency.
Upon intake, facility staff must provide resident with the following: <ul style="list-style-type: none"> <li>• Information about the facility and its services</li> <li>• Policies and procedures</li> <li>• Confidentiality</li> <li>• Safety issues</li> <li>• House rules and activities</li> <li>• Resident rights and responsibilities</li> <li>• Grievance procedures</li> <li>• Prevention</li> <li>• Risk reduction practices</li> <li>• Harm reduction</li> <li>• Licit and illicit drug interactions</li> <li>• Medical complications of substance use hepatitis</li> <li>• Important health and self-care practices information about referral agencies that are supportive of people living with HIV and AIDS</li> </ul>	Documentation of resident education on file in client chart.

### INDIVIDUAL SERVICES PLAN (ISP) – RCFCI

The RCFCI will ensure that there is an ISP for each resident. A services plan must be developed for all residents prior to admission based upon the initial assessment. This plan will serve as the framework for the type and duration of services provided during the resident's stay in the facility and should include the plan review and reevaluation schedule. The program staff will regularly observe each resident for changes in physical, mental, emotional and social functioning. The plan will also document mechanisms to offer or refer residents with HIV/AIDS to primary medical services and case management services. The provider will ensure that there will be an RN case manager who is responsible for the coordination and/or the provisions of the services specified in the ISP.

The ISP should be developed with the resident and will include the resident's background, medical and mental/emotional functioning and the facility's plans for providing services to meet the individual needs identified above. If the resident has a restricted health condition, the ISP must include the restricted health condition plan.

The plan will include, but not be limited to:

- ◆ Current health status

- ◆ Current mental health status
- ◆ Current functional limitations
- ◆ Current medications
- ◆ Medical treatment/therapy
- ◆ Specific services needed
- ◆ Intermittent home health care required
- ◆ Agencies or persons assigned to carry out services
- ◆ “Do not resuscitate” order, if applicable
- ◆ For each un-emancipated minor, the specific legal means of ensuring continuous care and custody when the parent or guardian is hospitalized, relocated, becomes unable to meet the child’s needs, or dies

All health services components of the plan will be developed and monitored in coordination with the provider of service and will reflect the elements of the resident’s plan of treatment developed by the ISP team. The plan will be updated every three months or more frequently as the resident’s condition warrants.

Services identified in the ISP should be provided directly or the facility should link the resident with outside resources. The facility will provide necessary personal assistance and care, as indicated in the ISP, with ADL including, but not limited to, dressing, eating and bathing.

While the plan will be updated as frequently as necessary to ensure its accuracy and to document significant occurrences that result in changes in the resident’s physical, mental and/or social functioning, residents receiving DHSP-funded RCFCI services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

If modifications to the plan identify an individual resident service need which is not being met by the facility, the facility must secure consultation to determine if the facility can meet the resident service need. If it is determined that the resident’s needs cannot be met, the facility should assist with relocation of the resident into an appropriate level of care.

### ***ISP TEAM***

The program will ensure that the ISP for each resident is developed by the ISP team.

In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the resident’s individual needs and service plan:

- ◆ The resident and/or his/her authorized representative
- ◆ The resident’s physician
- ◆ Facility house manager
- ◆ Direct care personnel
- ◆ Facility administrator/designee
- ◆ Social worker/placement worker
- ◆ Pharmacist, if needed
- ◆ For each un-emancipated minor, the child’s parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian
- ◆ Others, as deemed necessary

STANDARD	MEASURE
ISP will be completed prior to admission.	Needs and services plan on file in client chart.
The plan will include, but not be limited to: <ul style="list-style-type: none"> <li>• Current health status</li> <li>• Current mental health status</li> <li>• Current functional limitations</li> <li>• Current medications</li> <li>• Medical treatment/therapy</li> <li>• Specific services needed</li> <li>• Intermittent home health care required</li> <li>• Agencies or persons assigned to carry out services</li> <li>• “Do not resuscitate” order, if applicable</li> <li>• For each un-emancipated minor, the specific legal means of ensuring continuous care and custody when the parent or guardian is hospitalized, relocated, becomes unable to meet the child’s needs, or dies</li> </ul>	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a resident’s physical, mental, emotional and social functioning.	Updated needs and services plan on file in client chart.
Residents must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of reassessment on file in client chart.
If a resident’s needs cannot be met by facility, the facility will assist in relocating the resident to appropriate level of care.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each resident is developed by the ISP team. In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the resident’s ISP: <ul style="list-style-type: none"> <li>• The resident and/or his/her authorized representative</li> <li>• The resident’s physician</li> <li>• Facility house manager</li> <li>• Direct care personnel</li> <li>• Facility administrator/designee</li> <li>• Social worker/placement worker</li> <li>• Pharmacist, if needed</li> <li>• For each un-emancipated minor, the child’s parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian</li> <li>• Others, as deemed necessary</li> </ul>	Record of ISP team on file in client chart.

### MONTHLY CASE CONFERENCE – RCFCI

A monthly case conference will include review of the ISP, including the resident’s health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference will include the resident, the registered nurse, the case manager and direct care staff representatives. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the resident’s approval. The resident may also invite the participation of an advocate, family member or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and support for the resident.

STANDARD	MEASURE
All residents, registered nurse, case manager and direct care staff representatives will participate in monthly case conferences to review health and housing status, need for medical and supportive services and progress towards discharge.	Documentation of case conference on file in client chart including outcomes, participants and necessary steps.

### RESIDENTIAL CARE SERVICES – RCFCI

RCFCIs will have written policies, procedures, protocols and a current plan of operations for all services to be provided.

In addition to services specified in State Regulation 87860 required by applicable laws and regulations, which are to be provided by the licensee to operate and maintain a license to operate a RCFCI, the RCFCI provider will provide 24-hour care and supervision which will ensure the provision of basic services specified, but not limited to:

- ◆ Providing lodging in a clean, safe and healthful homelike residential setting which complies with all the State regulations applicable to RCFCIs
- ◆ Providing securable storage space for personal items
- ◆ Providing housekeeping services and utilities
- ◆ Making available access to adequate common areas including recreation areas
- ◆ Providing three meals a day and additional nourishments of the quality and quantity to meet each resident's basic nutritional needs, including special dietary needs, in accordance with physician's orders
- ◆ Providing kitchen space with adequate refrigerator space in the facility for residents who desire and are capable of preparing their own meals
- ◆ Ensuring that consultation with a nutritionist is made available to the resident for dietary needs including cultural dietary needs
- ◆ Providing a bedroom, with no more than two residents, individual beds and fresh linen
- ◆ Providing equipment and supplies necessary for residents' personal care and maintenance of adequate hygiene
- ◆ Providing an accessible telephone in working condition
- ◆ Providing laundry services or facilities
- ◆ Providing adequate space and privacy for residents to receive guests
- ◆ Performing regular observations and assessments of the resident's physical and mental condition
- ◆ Providing personal care services to help provide for and maintain the resident's physical and psychological comfort; these services include, but are not limited to, ADL and specific services needed and agencies or persons assigned to carry out services
- ◆ Arranging of transportation for medical, dental, therapeutic and counseling services
- ◆ Social and emotional support services of the resident's own choice
- ◆ Discharge assistance including, but not limited to, referral of residents to other available placement, if needed

### SERVICE AGREEMENTS – RCFCI

The provider will obtain and maintain written agreements or contracts with:

- ◆ A waste disposal company registered by the California Department of Toxic Substance Control and the California Department of Public Health if the provider will be generating or handling bio-hazardous waste
- ◆ A licensed home health care agency and individuals or agencies that will provide the following basic services:
  - Case management services
  - Counseling regarding HIV disease and AIDS, including current information on

treatment of the illness and its possible effects on the resident's physical and mental health

- Counseling on death, dying, and the grieving process; psychosocial support services; substance misuse counseling
- Nutritionist services
- Consultation on housing, health benefits, financial planning, and availability of other community-based and public resources; if these services are not provided by provider staff or the subcontracted home health agency personnel

STANDARD	MEASURE
<p>Programs will provide (at minimum):</p> <ul style="list-style-type: none"> <li>• Lodging in a clean, safe and healthful homelike residential setting which complies with all the State regulations applicable to RCFCIs</li> <li>• Securable storage space for personal items</li> <li>• Housekeeping services and utilities</li> <li>• Access to adequate common areas, including recreation areas</li> <li>• Three meals a day and additional nourishments of the quality and quantity to meet each resident's basic nutritional needs, including special dietary needs, in accordance with physician's orders</li> <li>• Kitchen space with adequate refrigerator space in the facility for residents who desire and are capable of preparing their own meals</li> <li>• Consultation with a nutritionist is made available to the resident for dietary needs including cultural dietary needs;</li> <li>• A bedroom, with no more than two residents, individual beds and fresh linen</li> <li>• Equipment and supplies necessary for residents' personal care and maintenance of adequate hygiene</li> <li>• An accessible telephone in working condition</li> <li>• Laundry services or facilities</li> <li>• Adequate space and privacy for residents to receive guests</li> <li>• Regular observations and assessments of the resident's physical and mental condition</li> <li>• Personal care services to help provide for and maintain the resident's physical and psychological comfort (e.g., ADL and specific services needed and agencies or persons assigned to carry out services)</li> <li>• Arranging of transportation for medical, dental, therapeutic and counseling services</li> <li>• Social and emotional support services of the resident's own choice</li> <li>• Discharge assistance including, but not limited to, referral of residents to other available placement, if needed</li> </ul>	<p>Program review and monitoring to confirm.</p>

STANDARD	MEASURE
<p>Programs will obtain and maintain written agreements or contracts with:</p> <ul style="list-style-type: none"> <li>• A waste disposal company registered by the California Department of Toxic Substance Control and the California Department of Public Health if generating or handling bio-hazardous waste</li> <li>• A licensed home health care agency and individuals or agencies that will provide the following basic services: <ul style="list-style-type: none"> <li>• Case management services</li> <li>• Counseling regarding HIV disease and AIDS, including current information on treatment of the illness and its possible effects on the resident's physical and mental health</li> <li>• Counseling on death, dying, and the grieving process; psychosocial support services; substance misuse counseling</li> <li>• Nutritionist services</li> <li>• Consultation on housing, health benefits, financial planning, and availability of other community-based and public resources; if these services are not provided by provider staff or the subcontracted home health agency personnel</li> </ul> </li> </ul>	<p>Written agreements on file at provider agency.</p>

#### **MEDICATION – RCFCI**

Administration of medication will only be performed by an appropriate skilled professional. Direct staff will be allowed to assist the resident with self-administration medications if the following conditions are met:

- ◆ Direct staff who provide assistance will have knowledge of medications and possible side effects and;
- ◆ On-the-job training in the facility's medication practices as specified in Section 87865 (g) 4.

#### **MEDICATION STORAGE**

The following will apply to medications which are centrally stored:

- ◆ Medications must be kept in a locked place that is not accessible to persons other than employees who are responsible for the supervision of the centrally stored medications.
- ◆ Keys used for medications must not be accessible to residents.
- ◆ All medications must be labeled and maintained in compliance with label instructions and state and federal laws.

#### **SELF-ADMINISTRATION MEDICATIONS**

Residents who are physically and mentally able to be responsible for their own medications will be permitted to do so under the following circumstances:

- ◆ All members of the ISP team is in agreement.
- ◆ The resident's ISP includes a statement that the resident is capable of administration of medication.
- ◆ The licensee provides the resident with a locked container in which to store the medication.
- ◆ There is more than one key to the container. One key will be given to the resident and the other is kept by direct staff.
- ◆ The licensee will consider all residents in the facility when making a decision regarding self-administered medications.

There will be a written agreement between the licensee and the resident that he/she will self-administer the medication. The agreement will state who will be responsible for



reordering medications. A copy of the agreement will be kept in the resident's file.

Direct care staff will notify the physician and the RN case manager of any change in the resident's capacity to self-administer medications.

### **MEDICATION PROCEDURE**

The appropriately skilled professional will not pre-pour medication that has not been prepackaged more than 12 hours prior to being taken by the resident.

STANDARD	MEASURE
Direct staff will assist the resident with self-administration medications if the following conditions are met: <ul style="list-style-type: none"> <li>Have knowledge of medications and possible side effects; and</li> <li>On-the-job training in the facility's medication practices as specified in Section 87865 (g) 4.</li> </ul>	Record of conditions on file at provider agency.
The following will apply to medications which are centrally stored: <ul style="list-style-type: none"> <li>Medications must be kept in a locked place that is not accessible to persons other than employees who are responsible for the supervision of the centrally stored medications.</li> <li>Keys used for medications must not be accessible to residents.</li> <li>All medications must be labeled and maintained in compliance with label instructions and state and federal laws.</li> </ul>	Record of conditions on file at provider agency.
Residents who are physically and mentally able to be responsible for their own medications will be permitted to do so under the following circumstances: <ul style="list-style-type: none"> <li>All members of the ISP team are in agreement.</li> <li>The resident's ISP includes a statement that the resident is capable of administration of medication.</li> <li>The program provides the resident with a locked container in which to store the medication.</li> <li>There is more than one key to the container. One key will be given to the resident and the other is kept by direct staff.</li> <li>The program will consider all residents in the facility when making a decision regarding self-administered medications.</li> </ul>	Record of conditions on file at provider agency.
There will be a written agreement between the program and the resident that he/she will self-administer the medication. The agreement will state who will be responsible for reordering medications. A copy of the agreement will be kept in the resident's file.	Written agreement on file in client chart.
Direct care staff will notify the physician and the RN case manager of any change in the resident's capacity to self-administer medications.	Notification of any change on file in client chart.
The appropriately skilled professional will not pre-pour medication that has not been prepackaged more than 12 hours prior to being taken by the resident.	Program review and monitoring to confirm.

### **SUPPORT SERVICES – RCFCI**

Support services that are to be provided or coordinated must include, but are not limited to:

- ◆ Provision and oversight of personal and supportive services (assistance with ADL and instrumental ADL)
- ◆ Health-related services (e.g. medication management services)

- ◆ Transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Recreational activities
- ◆ Meals
- ◆ Housekeeping and laundry
- ◆ Transportation
- ◆ Provision and/or coordination of all services identified in the ISP
- ◆ Assistance with taking medication
- ◆ Central storing and/or distribution of medications
- ◆ Arrangement of and assistance with medical and dental care
- ◆ Maintenance of house rules for the protection of residents
- ◆ Arrangement and managing of resident schedules and activities
- ◆ Maintenance and/or management of resident cash resources or property

STANDARD	MEASURE
<p>Programs will provide or coordinate the following (at minimum):</p> <ul style="list-style-type: none"> <li>• Provision and oversight of personal and supportive services</li> <li>• Health-related services</li> <li>• Transmission risk assessment and prevention counseling</li> <li>• Social services</li> <li>• Recreational activities</li> <li>• Meals</li> <li>• Housekeeping and laundry</li> <li>• Transportation</li> <li>• Provision and/or coordination of all services identified in the ISP</li> <li>• Assistance with taking medication</li> <li>• Central storing and/or distribution of medications</li> <li>• Arrangement of and assistance with medical and dental care</li> <li>• Maintenance of house rules for the protection of residents</li> <li>• Arrangement and managing of resident schedules and activities</li> <li>• Maintenance and/or management of resident cash resources or property.</li> </ul>	<p>Program policy and procedures to confirm. Record of services and referrals on file in client chart.</p>

#### RECREATIONAL ACTIVITIES – RCFCI

The facility will ensure that planned recreational activities are provided for the residents. Each resident who is capable will be given an opportunity to participate in the planning, preparation, conducting, clean-up, and critiquing of the activities. Residents will be encouraged to participate in activities planned to meet their individual needs. The activities will have a written, planned schedule of social and other purposeful independent or group activities. The activities will be designed to make life more meaningful, to stimulate and support physical and mental capabilities, and to enable the resident to maintain the highest attainable social, physical, and emotional functioning.

The activity program will consist of individual, small and large group activities which are designed to meet the needs and interests of each resident to include, but are not limited to:

- ◆ Worship services and activities of the resident's choice
- ◆ Community service activities
- ◆ Community events including, but not limited to, concerts, tours, dances, plays and celebrations of special events

- ◆ Self-help organizations
- ◆ Senior citizen groups, sport leagues and service clubs

STANDARD	MEASURE
Facilities will plan activities on a regular basis.	Activity plans on file at provider agency.
Residents will be given information about and an opportunity to participate in community activities.	Program review and monitoring to confirm.

### **VOLUNTEER ASSISTANCE – RCFCI**

Such services will include, but not be limited to, companionship, transportation, respite care, errands and emotional and spiritual support. Provider agrees that volunteers will not be used as substitutes for required personnel.

Volunteers providing resident care services will:

- ◆ Be provided clearly defined roles and written job descriptions
- ◆ Receive orientation and training equivalent to that provided paid staff
- ◆ Possess education and experience equal to that required of paid staff performing similar functions
- ◆ Conform to the RCFCI policies and procedures
- ◆ Receive periodic performance evaluations

STANDARD	MEASURE
Programs will provide volunteer activities.	Volunteer activities on file at provider agency.

### **EMERGENCY MEDICAL TREATMENT – RCFCI**

Residents receiving RCFCI services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility. The cost of such transportation as well as the cost of emergency medical care will not be a charge to nor reimbursable under RCFCI services. The provider will have a written agreement(s) with a licensed medical facility(ies) within the community for provision of emergency services as appropriate.

STANDARD	MEASURE
Residents requiring emergency medical treatment will be transported to medical facility at provider's expense.	Program review and monitoring to confirm.
The provider will have a written agreement(s) with a licensed medical facility(ies) within the community for provision of emergency services as appropriate.	Written agreement(s) on file at provider agency.

### **DISCHARGE PLANNING – RCFCI**

Discharge planning services include, but are not limited to, RCFCIs providing discharge planning services to clients that include (at minimum):

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, meals, nutritional support and transportation)
- ◆ Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing and referral

- ◆ Housing such as permanent housing, independent housing, supportive housing, long-term assisted living or other appropriate housing

#### **DISCHARGE/TRANSFER SUMMARY**

In all cases, a Discharge/Transfer Summary will be completed for all residents discharged from the agency. The Discharge Summary will be completed by the RN case manager or the social worker.

The summary will include, but not be limited to:

- ◆ Admission and discharge dates
- ◆ Services provided
- ◆ Diagnosis(es)
- ◆ Status upon discharge
- ◆ Notification date of discharge
- ◆ Reason for discharge
- ◆ Transfer information, as applicable

STANDARD	MEASURE
When feasible discharge planning services will be provided to clients to include: <ul style="list-style-type: none"> <li>• Linkage to primary medical care</li> <li>• Linkage to supportive services</li> <li>• Early intervention services</li> <li>• Long-term housing</li> </ul>	Discharge plan on file in client chart.
A Discharge/Transfer Summary will be completed for all residents discharged from the agency. The summary will include, but not be limited to: <ul style="list-style-type: none"> <li>• Admission and discharge dates</li> <li>• Services provided</li> <li>• Diagnosis(es)</li> <li>• Status upon discharge</li> <li>• Notification date of discharge</li> <li>• Reason for discharge</li> <li>• Transfer information, as applicable</li> </ul>	Discharge/Transfer Summary on file in client chart.

#### **EMERGENCY AND DISASTER PLAN – RCFCI**

Programs will have an emergency and disaster plan, describing the procedures and actions to be taken in the event of an emergency, disaster, or disturbance to safeguard residents and facility staff. Situations to be addressed in the plan will include emergency medical treatment for physical illness or injury of residents, earthquake, fire, flood, resident disturbance, and work action. The plan will include the program’s specific procedures for providing this information to all program staff.

STANDARD	MEASURE
Programs will have an emergency and disaster plan, describing the procedures and actions to be taken in the event of an emergency, disaster, or disturbance to safeguard residents and facility staff.	Emergency and disaster plan on file at provider agency.

#### **PROGRAM RECORDS – RCFCI**

Programs will maintain a separate, complete and current record for each resident in sufficient detail to permit an evaluation of services.

Such records will include, but not be limited to:

- ◆ Resident demographic data, including dates of admission and discharge
- ◆ Signed copy of the admission agreement
- ◆ Names, addresses, and telephone numbers of physician, case manager, and other medical and mental health providers, if any
- ◆ Names, addresses, and telephone numbers of any person or agency responsible for the care of a resident, including, but not limited to, persons who have been granted durable power of attorney for the resident or conservators for the resident and/or his/her estate
- ◆ Medical assessment, including ambulatory status
- ◆ Documentation of AIDS or symptomatic HIV disease diagnosis
- ◆ Written certification by duly authorized health care professional that the resident and each family unit member residing in provider's RCFCI are free from active TB
- ◆ Copy of current child care contingency plan
- ◆ Current ISP
- ◆ Documentation of all contacts made with the ISP team members
- ◆ Documentation of all services provided to resident, including those furnished by consultants and subcontractors' staff
- ◆ Medication record
- ◆ Documentation of observations and assessments made about resident's physical and mental condition

These notations will be dated and include, but not limited to, type of service provided, resident's response, if applicable, and signature and title of person providing the service.

STANDARD	MEASURE
Programs will maintain sufficient records on each resident.	<p>Client records on file at provider agency that include (at minimum):</p> <ul style="list-style-type: none"> <li>• Resident demographic data</li> <li>• Admission agreement</li> <li>• Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers, if any</li> <li>• Names, addresses and telephone numbers of any person or agency responsible for the care of a resident</li> <li>• Medical assessment</li> <li>• Documentation of AIDS or symptomatic HIV disease progression</li> <li>• Written certification that each family unit member free from active TB</li> <li>• Copy of current child care contingency plan</li> <li>• Current ISP</li> <li>• Record of IST contacts</li> <li>• Documentation of all services provided</li> <li>• Record of current medications</li> <li>• Physical and mental health observations and assessments</li> </ul>

## HOUSING SERVICES

HIV housing services provide a variety of emergency, transitional and permanent housing options for people living with HIV. All housing services will be culturally and linguistically appropriate to the target population. In addition, HIV housing services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid clients in attaining self-sufficiency.

HIV housing services will be offered to medically indigent (uninsured or unable to get insurance), persons living in Los Angeles County.

HIV housing services provided in Los Angeles County can include:

- ◆ Hotel/motel and meal vouchers
- ◆ Emergency shelter programs
- ◆ Transitional housing programs
- ◆ Permanent supportive housing programs

STANDARD	MEASURE
HIV housing services will respect inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid clients in attaining self-sufficiency.	Supervision and program review to confirm.

## HOTEL/MOTEL AND MEAL VOUCHERS

The primary goal of the hotel/motel and meal voucher program is to prevent people living with HIV from sleeping in places not meant for human habitation when appropriate emergency shelter is unavailable. While the central coordinating agency (CCA) serves as the focal point for the provision of these services, clients are unable to access hotel/motel and meal vouchers unless they are receiving case management services from a designated referral agency.

### GENERAL REQUIREMENTS – HOTEL/MOTEL AND MEAL VOUCHERS

Hotel/motel and meal vouchers are available for a maximum of 30 days per year. To access hotel/motel and meal vouchers, a client must be receiving case management services from a designated referral agency.

Case management services will ensure that the client:

- ◆ Has a definitive housing plan that assesses his/her housing needs and assists them in obtaining longer term housing within the 30-day limit (residential substance abuse or mental health treatment program, residential care facility for the chronically ill, transitional housing or permanent housing)
- ◆ Is receiving supporting services that promote stabilization, including needs assessments, case management, mental health counseling and treatment, substance abuse counseling and treatment, benefits counseling, individual case planning, budget counseling, assistance in locating and obtaining affordable housing and follow-up services

STANDARD	MEASURE
Vouchers are available for a maximum of 30 days per year.	Program record review and monitoring to confirm.
Clients must be receiving case management services from a designated referral agency to be eligible.	Documentation of case management services in client chart including housing plan and supportive service utilization.

### ELIGIBILITY REQUIREMENTS – HOTEL/MOTEL AND MEAL VOUCHERS

To be eligible to receive hotel/motel and meal vouchers a client must:

- ◆ Be diagnosed HIV symptomatic/asymptomatic or AIDS with verifiable documentation
- ◆ Have a state-recognized identification document
- ◆ Be homeless and residing or moving to Los Angeles County
- ◆ Meet current HUD income eligibility guidelines and have proof of income if applicable

- ◆ Be working with an authorized referral agency and possess a designated housing plan

An eligible client may be vouchered with extended family members, spouses, significant others, dependents and/or caregivers.

STANDARD	MEASURE
Clients must meet eligibility requirements to receive hotel/motel and meal vouchers.	Documentation of eligibility on file in client chart .
Clients may be vouchered with extended family members, spouses, significant others, dependents and/or caregivers.	Program review and monitoring to confirm.

### VOUCHER REQUESTS – HOTEL/MOTEL AND MEAL VOUCHERS

Clients who qualify for hotel/motel and meal vouchers may access this service for no more than 30 days per contract year and in increments of no more than seven days at a time. Throughout the period of time receiving hotel/motel and meal vouchers, a client must be compliant with the housing plan designed in conjunction with his/her case manager. Case managers should attempt to secure other types of housing prior to exhausting a client's emergency voucher limit. Under no circumstances should clients be referred directly to the CCA. A representative from a referral agency must always request services on behalf of his/her client.

Under extenuating circumstances, a client may receive more than 30 days of hotel/motel and meal vouchers under this program (e.g., a client is on a waiting list for a housing program with a designated move-in date that extends past the 30 day period). Such extensions are made on a case-by-case basis and must be carefully verified.

Clients needing after hours service are referred to 211 LA County directly and, if eligible, will be referred to the CCA after-hour representative.

STANDARD	MEASURE
Clients can receive vouchers for no more than 30 days in a contract year in increments of no more than seven days at a time.	Program review and monitoring to confirm.
Clients receiving vouchers must be compliant with housing plan.	Program review and monitoring to confirm.

### REQUIRED DOCUMENTATION – HOTEL/MOTEL AND MEAL VOUCHERS

The following documents are required to complete the initial hotel/motel and meal voucher process:

- ◆ Client Intake Form – signed by both client and the case manager
- ◆ Case Management Housing Plan/Consent to Release Information – signed by client
- ◆ Rules and Regulations – reviewed by case manager and signed by both the case manager and the client
- ◆ Diagnosis Form
- ◆ Identification for all adults over 18 included on the voucher

When a request to extend hotel/motel and meal vouchers is received, the following documentation must accompany the request

- ◆ Updated Case Management Plan – including the follow-up with previous and continuing housing plans
- ◆ Hotel and Restaurant Client Evaluation Forms



Other documentation that may be required during the process includes:

- ◆ Agency Move-In Confirmation – necessary when vouchering beyond 21 nights — confirming exact date a client is to enter the new housing program
- ◆ Closeout Letter – required prior to a client utilizing his/her final seven nights of vouchering and documents a client’s awareness of the upcoming termination of service

STANDARD	MEASURE
Case managers from referring agencies will provide required documentation of client eligibility.	Documentation on file in client chart to include: <ul style="list-style-type: none"> <li>• Intake form</li> <li>• Case management housing plan/consent to release information</li> <li>• Rules and regulations</li> <li>• Diagnosis Form</li> <li>• Client identification</li> </ul>
Case managers requesting voucher extensions for clients will provide required documentation	Documentation on file in client chart to include: <ul style="list-style-type: none"> <li>• Updated housing plan</li> <li>• Hotel and restaurant client evaluation forms</li> </ul>

## EMERGENCY SHELTER PROGRAMS (ESPS)

### GENERAL REQUIREMENTS – ESPS

Each ESP must adhere to the following general requirements:

- ◆ Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- ◆ Assist with transportation arrangements for clients who do not have independent arrangements
- ◆ Provide ample opportunity for family participation in activities in the facility
- ◆ Include a safety plan to include precautions enacted to protect clients (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- ◆ Develop a disaster plan for implementation during fires, earthquakes, etc.

STANDARD	MEASURE
ESPs must meet the following general requirements: <ul style="list-style-type: none"> <li>• Maintain plan of operation</li> <li>• Assist with transportation arrangements</li> <li>• Provide opportunity for family participation</li> <li>• Develop safety plan as needed</li> <li>• Develop a disaster plan</li> </ul>	Program review and monitoring to confirm.

### INTAKE – ESPS

Client intake is required for all clients who request or are referred to HIV emergency shelter programs. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. The nature of emergency shelter may preclude having important intake information prior to admission. Upon acceptance into emergency shelter programs, prospective clients, their authorized representatives and/or assigned case managers will be interviewed as soon as reasonably possible to intake, assess and educate.

In the intake process and throughout HIV emergency shelter program service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information.

As part of the intake process, the client file will include the following information (at a minimum):

- ◆ Proof of HIV diagnosis
- ◆ Proof of income
- ◆ Proof of residence in Los Angeles County

**Required Forms:** Programs must develop the following forms in accordance with state and local guidelines.

Completed forms are required for each client:

- ◆ Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- ◆ Consent to Receive Services
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Client Rights and Responsibilities
- ◆ Client Grievance Procedures

STANDARD	MEASURE
Intake process is begun as soon as possible upon admission.	Intake tool is completed and in client file.
Eligibility for services is determined.	Client's file includes: <ul style="list-style-type: none"> <li>• Proof of HIV diagnosis</li> <li>• Proof of income</li> <li>• Proof of Los Angeles County residence</li> </ul>
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

## ASSESSMENT AND EDUCATION – ESPS

### ASSESSMENT

At minimum, each prospective client will be assessed to identify strengths and gaps in his/her support system as a means to move toward permanent housing.

Assessments will include the following:

- ◆ Age
- ◆ Health status
- ◆ Family involvement
- ◆ Family composition
- ◆ Special housing needs
- ◆ Level of independence
- ◆ ADLs
- ◆ Income
- ◆ Public entitlements

- ◆ Substance abuse
- ◆ Mental health
- ◆ Credit history
- ◆ History of evictions
- ◆ Level of resources available to solve problems
- ◆ Co-morbidity factors

### **EDUCATION**

Participant education is a continuous process.

Upon intake, clients should be educated about the facility, policies and procedures and services to include (at minimum):

- ◆ Confidentiality
- ◆ Safety issues
- ◆ House rules and activities
- ◆ Client rights and responsibilities
- ◆ Grievance procedures
- ◆ Prevention
- ◆ Risk reduction practices
- ◆ Harm reduction
- ◆ Licit and illicit drug interactions
- ◆ Medical complications of substance abuse
- ◆ Hepatitis
- ◆ TB
- ◆ HIV prevention needs
- ◆ Health and self-care practices
- ◆ Referral information

STANDARD	MEASURE
As soon as possible after admission a client or representative will be interviewed to complete eligibility determination, assessment and client education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: <ul style="list-style-type: none"> <li>• Age</li> <li>• Health status</li> <li>• Family involvement</li> <li>• Family composition</li> <li>• Special housing needs</li> <li>• Level of independence</li> <li>• ADL</li> <li>• Income</li> <li>• Public entitlements</li> <li>• Substance abuse</li> <li>• Mental health</li> <li>• Credit history</li> <li>• History of evictions</li> <li>• Level of resources available to solve problems</li> <li>• Co-morbidity factors</li> </ul>	Signed, dated assessment on file in client chart.

## NEEDS AND SERVICES PLAN\* – ESPS

Based upon the initial assessment, a needs and services plan that identifies resources for housing and referrals to appropriate medical and social services will be completed for each participant within one week of admission. Needs and services plans will include a housing plan that addresses the short-term and long-term housing needs of the client. Plans also will serve to identify specialized services needed to maintain the client in housing and access and adherence to primary medical care services.

*(\*Needs and services plan complies with contract/licensure requirements, and is reflective of ISPs noted in other standards.)*

STANDARD	MEASURE
<ul style="list-style-type: none"> <li>Needs and services plan will be completed within seven days of acceptance into services.</li> </ul>	Needs and services plan on file in client chart signed by client detailing housing resources and referrals made.

## CONTAGIOUS AND INFECTIOUS DISEASE MANAGEMENT – ESPS

All clients in emergency shelter programs must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements (<http://lapublichealth.org/tb/index.htm>). As the nature of emergency shelter services may preclude having exhaustive information prior to a client's admission, it is required that clients be observed and questioned about health status and any symptoms that may indicate contagious or infectious disease as soon as possible after he or she should be isolated and a physician should be consulted to determine the suitability of that client's continued residence in the program.

STANDARD	MEASURE
Clients must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements.	Program review and monitoring to confirm.
Clients exhibiting symptoms of infectious or contagious disease will be isolated until a physician is consulted.	Record of isolation and physician consult on file in client chart.

## HOUSING SERVICES – ESPS

ESPs will provide the following for their clients (at minimum):

- ◆ Twenty-four hour access to lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol- and drug-free
- ◆ Three balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable)
- ◆ Adequate heating and lighting, plumbing, hot and cold water, toiletries and bathing facilities
- ◆ Accessible telephone in working condition, available for clients to make local phone calls that are job-, family- or housing-related
- ◆ Laundry services or facilities

In addition, it is strongly recommend that the following services be provided as appropriate:

- ◆ Self-sufficiency development services (including life-skills training, financial stability planning, etc.), with the ultimate goal of moving recently homeless persons to permanent housing as quickly as possible
- ◆ Supportive services including referrals to case management, medical and social services

STANDARD	MEASURE
Programs will provide (at minimum): <ul style="list-style-type: none"> <li>• Clean, safe lodging</li> <li>• Three balanced meals daily</li> <li>• Adequate heat, light, plumbing and bathing facilities</li> <li>• Telephone access</li> <li>• Laundry services or facilities</li> </ul>	Program review and monitoring to confirm.

### REFERRAL SERVICES – ESPS

Emergency shelter programs will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related services. Programs must maintain a comprehensive list of target providers including, but not limited to, HIV LA.

In addition to transitional and permanent housing referrals, programs will refer and link clients to services consistent with their needs, including, but not be limited to:

- ◆ Medical care
- ◆ Oral health care
- ◆ Mental health treatment
- ◆ Substance abuse treatment
- ◆ Case management
- ◆ Peer support
- ◆ Vocational training
- ◆ Education
- ◆ Legal and financial services
- ◆ Treatment education

Programs will make available to clients information about public health, social services and where to apply for State, federal and/or county entitlement programs.

STANDARD	MEASURE
Programs will demonstrate active collaboration with providers.	Memoranda of Understanding on file at provider agency.
Programs must maintain a list of target providers for full spectrum of HIV-related services.	Referral list on file at provider agency.
Programs will refer and link clients to services including (but not limited to): <ul style="list-style-type: none"> <li>• Transitional and permanent housing</li> <li>• Medical care</li> <li>• Oral health care</li> <li>• Mental health treatment</li> <li>• Substance abuse treatment</li> <li>• Case management</li> <li>• Peer support</li> <li>• Vocational training</li> <li>• Education</li> <li>• Legal and financial services</li> <li>• Treatment education</li> </ul>	Signed, dated progress notes on file in client chart to detail referrals and linkages.
Programs will provide clients with public health and social service entitlement program information.	Signed, dated progress notes on file in client chart to detail.

### SUPPORTIVE SERVICES – ESPS

Programs providing emergency shelter will provide or coordinate the following services (at minimum):

- ◆ Health-related services (medical care, medication management, adherence, etc.)

- ◆ HIV transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Housekeeping and laundry
- ◆ Transportation

STANDARD	MEASURE
Programs will provide or coordinate the following (at minimum): <ul style="list-style-type: none"> <li>• Health-related services</li> <li>• HIV transmission risk assessment and prevention counseling</li> <li>• Social services</li> <li>• Housekeeping and laundry</li> <li>• Transportation.</li> </ul>	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

### DISCHARGE PLANNING – ESPS

When feasible, discharge planning services will be provided to clients which includes (at minimum):

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, meals, transportation)
- ◆ Early intervention services to link people living with HIV into care, including outreach, HIV counseling and testing and referral
- ◆ Housing services such as transitional housing, permanent housing, independent housing, supportive housing, etc.

STANDARD	MEASURE
When feasible discharge planning services will be provided to clients to include: <ul style="list-style-type: none"> <li>• Linkage to primary medical care</li> <li>• Linkage to supportive services</li> <li>• Early intervention services</li> <li>• Housing services</li> </ul>	Discharge plan on file in client chart.

### PROGRAM RECORDS – ESPS

Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services to include (at minimum):

- ◆ Documentation of participant's HIV status
- ◆ Housing status prior to admission
- ◆ Signed, written program participant's rights agreement
- ◆ Participant data, including dates of admission and discharge and emergency notification information
- ◆ Documentation of evaluations performed and referrals made for medical care and supportive services
- ◆ Name of case management agency in which participant is enrolled or to which participant has been referred
- ◆ Documentation of program participation
- ◆ Written certification from authorized health care professional that the participant is free from active TB (must be obtained prior to admission for those programs that do not provide single occupancy rooms)

STANDARD	MEASURE
Programs will maintain sufficient records on each participant.	<p>Client records on file at provider agency that include (at minimum):</p> <ul style="list-style-type: none"> <li>• HIV documentation</li> <li>• Prior housing status</li> <li>• Program participant's and rights agreement</li> <li>• Participant data</li> <li>• Evaluations performed and referrals made</li> <li>• Name of case management agency</li> <li>• Documentation of participation</li> <li>• TB clearance (when indicated).</li> </ul>

## TRANSITIONAL HOUSING PROGRAMS (THPS)

### GENERAL REQUIREMENTS – THPS

Each THP must adhere to the following general requirements:

- ◆ Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- ◆ Assist with transportation arrangements for clients who do not have independent arrangements
- ◆ Provide ample opportunity for family participation in activities in the facility
- ◆ Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- ◆ Develop a disaster plan for implementation during fires, earthquakes, etc.

STANDARD	MEASURE
<p>Transitional housing programs must meet the following general requirements:</p> <ul style="list-style-type: none"> <li>• Maintain plan of operation</li> <li>• Assist with transportation arrangements</li> <li>• Provide opportunity for family participation</li> <li>• Develop safety plan as needed</li> <li>• Develop a disaster plan</li> </ul>	Program review and monitoring to confirm.

### INTAKE – THPS

Client intake is required for all clients who request or are referred to HIV transitional housing programs. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. Upon acceptance into transitional housing programs, prospective clients, their authorized representatives and/or assigned case managers will be interviewed as soon as reasonably possible to intake, assess and educate.

During the intake process and throughout HIV THP service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released.)



As part of the intake process, the client file will include the following information (at minimum):

- ◆ Proof of HIV diagnosis
- ◆ Proof of income
- ◆ Proof of residence in Los Angeles County

**Required Forms:** Programs must develop the following forms in accordance with state and local guidelines.

Completed forms are required for each client:

- ◆ Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)
- ◆ Consent to Receive Services
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Client Rights and Responsibilities
- ◆ Client Grievance Procedures

STANDARD	MEASURE
Intake process is begun as soon as possible upon acceptance	Intake tool is completed and in client file
Eligibility for services is determined	Client's file includes: <ul style="list-style-type: none"> <li>• Proof of HIV diagnosis</li> <li>• Proof of income</li> <li>• Proof of Los Angeles County residence</li> </ul>
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

## ASSESSMENT AND EDUCATION – THPS

### ASSESSMENT

At minimum, each prospective client will be assessed to identify strengths and gaps in his/her support system as a means to move toward permanent housing. Assessments will include the following:

- ◆ Age
- ◆ Health status
- ◆ Family involvement
- ◆ Family composition
- ◆ Special housing needs
- ◆ Level of independence
- ◆ ADLs
- ◆ Income
- ◆ Public entitlements
- ◆ Substance abuse
- ◆ Mental health
- ◆ Credit history
- ◆ History of evictions
- ◆ Level of resources available to solve problems
- ◆ Co-morbidity factors

## EDUCATION

Participant education is a continuous process.

Upon intake, clients should be educated about the facility, policies and procedures and services to include (at minimum):

- ◆ Confidentiality
- ◆ Safety issues
- ◆ House rules and activities
- ◆ Client rights and responsibilities
- ◆ Grievance procedures
- ◆ Prevention
- ◆ Risk reduction practices
- ◆ Harm reduction
- ◆ Licit and illicit drug interactions
- ◆ Medical complications of substance abuse
- ◆ Hepatitis
- ◆ TB
- ◆ HIV prevention needs
- ◆ Health and self-care practices
- ◆ Referral information

STANDARD	MEASURE
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: <ul style="list-style-type: none"> <li>• Age</li> <li>• Health status</li> <li>• Family involvement</li> <li>• Family composition</li> <li>• Special housing needs</li> <li>• Level of independence</li> <li>• ADLs</li> <li>• Income</li> <li>• Public entitlements</li> <li>• Substance abuse</li> <li>• Mental health</li> <li>• Credit history</li> <li>• History of evictions</li> <li>• Level of resources available to solve problems</li> <li>• Co-morbidity factors</li> </ul>	Signed, dated assessment on file in client chart.

## NEEDS AND SERVICES PLAN\* – THPS

Based upon the initial assessment, a needs and services plan that identifies resources for permanent housing and referrals to appropriate medical and social services will be completed for each participant prior to admission. Needs and services plans will include a housing plan that addresses the short-term and long-term housing needs of the client. Plans will also serve to identify specialized services needed to maintain the client in housing and access and adherence to primary medical care services.

*(\*Needs and Services Plan complies with contract/licensure requirements, and is reflective of ISPs noted in other standards.)*

STANDARD	MEASURE
Needs and services plan will be completed prior to admission.	Needs and services plan on file in client chart signed by client detailing permanent housing resources and referrals made.

### CONTAGIOUS AND INFECTIOUS DISEASE MANAGEMENT – THPS

All clients in THPs must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements (<http://lapublichealth.org/tb/index.htm>). It is required that clients be observed and questioned about health status and any symptoms that may indicate contagious or infectious disease as soon as possible after admission. If a client is suspected of having an infectious or contagious disease, he or she should be isolated and a physician should be consulted to determine the suitability of that client's continued residence in the program. Ongoing annual re-screenings (including chest X-rays) are required for participants staying in transitional housing programs for more than one year.

STANDARD	MEASURE
Clients must meet County of Los Angeles Department of Public Health Tuberculosis Control Program admission requirements.	Program review and monitoring to confirm.
Clients exhibiting symptoms of infectious or contagious disease will be isolated until a physician is consulted.	Record of isolation and physician consult on file in client chart.
Annual re-screenings are required for program participants.	Record of annual re-screening on file in client chart.

### HOUSING SERVICES – THPS

Programs providing transitional housing will provide the following for their clients (at minimum):

- ◆ Twenty-four hour access to lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol- and drug-free
- ◆ Making facilities available to prepare, have delivered or be referred for at three balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable)
- ◆ Adequate heating and lighting, plumbing, hot and cold water, toiletries and bathing facilities
- ◆ Accessible telephone in working condition, available for clients to make local phone calls that are job-, family- or housing-related
- ◆ Laundry services or facilities
- ◆ Self-sufficiency development services (including life-skills training, financial stability planning, etc.), with the ultimate goal of moving recently homeless persons to permanent housing as quickly as possible
- ◆ Supportive services including referrals to case management, medical and social services

STANDARD	MEASURE
Programs will provide (at minimum): <ul style="list-style-type: none"> <li>• Clean, safe lodging</li> <li>• Facilities to prepare or be referred for three balanced meals daily</li> <li>• Adequate heat, light, plumbing and bathing facilities</li> <li>• Telephone access</li> <li>• Laundry services or facilities</li> <li>• Self-sufficiency development services</li> <li>• Supportive services including referral</li> </ul>	Program review and monitoring to confirm.

## SUPPORTIVE SERVICES – THPS

Transitional housing programs will provide or coordinate the following services (at minimum):

- ◆ Provision and oversight of personal and supportive services (assistance with ADL and instrumental ADL)
- ◆ Health-related services (medical care, medication management, adherence, etc.)
- ◆ HIV transmission risk assessment and prevention counseling
- ◆ Social services
- ◆ Recreational activities
- ◆ Meals
- ◆ Housekeeping and laundry
- ◆ Transportation

STANDARD	MEASURE
THPs will provide or coordinate the following (at minimum): <ul style="list-style-type: none"> <li>• Provision and oversight of personal and supportive services</li> <li>• Health-related services</li> <li>• HIV transmission risk assessment and prevention counseling</li> <li>• Social services</li> <li>• Recreational activities</li> <li>• Meals</li> <li>• Housekeeping and laundry</li> <li>• Transportation</li> </ul>	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

## REFERRAL SERVICES – THPS

THPs will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related services. Programs must maintain a comprehensive list of target providers including, but not limited to, the HIV LA Resource Directory.

In addition to permanent housing referrals, programs will refer and link clients to services consistent with their needs, including, but not be limited to:

- ◆ Medical care
- ◆ Mental health treatment
- ◆ Substance abuse treatment
- ◆ Case management
- ◆ Peer support
- ◆ Vocational training
- ◆ Education
- ◆ Legal and financial services
- ◆ Treatment education
- ◆ Dental treatment

Programs will make available to clients information about public health, social services and where to apply for State, federal and/or county entitlement programs.

STANDARD	MEASURE
Programs will demonstrate active collaboration with providers of HIV-related services.	Memoranda of Understanding on file at provider agency.
Programs must maintain a list of target providers to full spectrum of HIV-related services.	Referral list on file at provider agency.

STANDARD	MEASURE
Programs will refer and link clients to services including (but not limited to): <ul style="list-style-type: none"> <li>• Permanent housing</li> <li>• Medical care</li> <li>• Mental health treatment</li> <li>• Substance abuse treatment</li> <li>• Case management</li> <li>• Peer support</li> <li>• Vocational training</li> <li>• Education</li> <li>• Legal and financial services</li> <li>• Treatment education</li> <li>• Oral health care</li> </ul>	Signed, dated progress notes on file in client chart to detail referrals and linkages.
Programs will provide clients with public health and social service entitlement program information.	Signed, dated progress notes on file in client chart to detail.

### DISCHARGE PLANNING – THPS

When feasible, discharge planning services will be provided to clients that include (at minimum):

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, meals, transportation)
- ◆ Early intervention services to link people living with HIV into care, including outreach, HIV counseling and testing and referral
- ◆ Housing such as permanent housing, independent housing, supportive housing, etc.

STANDARD	MEASURE
When feasible discharge planning services will be provided to clients to include: <ul style="list-style-type: none"> <li>• Linkage to primary medical care</li> <li>• Linkage to supportive services</li> <li>• Early intervention services</li> <li>• Housing services</li> </ul>	Discharge plan on file in client chart.

### PROGRAM RECORDS – THPS

Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services to include (at minimum):

- ◆ Documentation of participant's HIV status
- ◆ Housing status prior to admission
- ◆ Written certification from an authorized health care professional that participant is free from active TB
- ◆ Signed, written program and housing rights agreement
- ◆ Participant data, including dates of admission and discharge and emergency notification information
- ◆ Documentation of case management services provided, including assessment of needs, assistance with goal development and housing plan and weekly progress toward accomplishment of goals/plan
- ◆ Name of case management agency in which participant is enrolled or to which participant has been referred
- ◆ Documentation of provision of or referral to drug or alcohol abuse counseling
- ◆ Documentation of program participation

STANDARD	MEASURE
Programs will maintain sufficient records on each participant.	<p>Client records on file at provider agency that include (at minimum):</p> <ul style="list-style-type: none"> <li>• HIV documentation</li> <li>• Prior housing status</li> <li>• TB clearance</li> <li>• Program and housing rights agreement</li> <li>• Participant data</li> <li>• Documentation of case management services</li> <li>• Documentation of case management agency or referral</li> <li>• Documentation of provision or referral to substance abuse services</li> </ul>

## PERMANENT SUPPORTIVE HOUSING PROGRAMS (PSHPS)

PSHP services include permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and services needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. While programs cannot, in most cases, require tenants to use supportive services, they will make every attempt to encourage and engage tenants to do so. Permanent supportive housing can be provided either in a congregate setting or through scattered-site master leasing.

### GENERAL REQUIREMENTS – PSHPS

Programs providing permanent housing with supportive services will comply with program requirements of the funding entity. Programs that provide rental subsidies will do so in accordance with guidelines approved by the subsidizing entity.

All PSHPs will be culturally and linguistically appropriate to the target population. In addition, HIV permanent housing services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid in attaining self-sufficiency.

STANDARD	MEASURE
HIV permanent supportive housing services will respect inherent dignity of clients and will be client-centered, aiming to foster client self-determination and aid in attaining self-sufficiency.	Supervision and program review to confirm.

### OUTREACH – PSHPS

PSHPs will conduct outreach activities to potential clients and HIV service providers to promote the availability of and access to HIV permanent supportive housing programs. Programs will work in collaboration with HIV primary health care and supportive services providers, as well as HIV testing sites. The purpose of outreach activities will be to identify appropriate clients who may have failed in previous housing environments and who may benefit from permanent housing with supportive services.

STANDARD	MEASURE
<ul style="list-style-type: none"> <li>PHSPs will outreach to potential clients and providers.</li> </ul>	Outreach plan on file at provider agency.
<ul style="list-style-type: none"> <li>Programs will collaborate with primary health care and supportive service providers.</li> </ul>	Memoranda of Understanding on file at the provider agency.

### TENANT SELECTION – PSHPS

PSHPs will comply with relevant federal, state and local fair housing laws in selecting tenants for housing, including (but not limited to):

- ◆ Title VIII of the Civil Rights Act of 1968
- ◆ 1982 Civil Rights Act of 1966
- ◆ 1981 Civil Rights Act of 1966
- ◆ Rehabilitation Act of 1973

Providers of permanent supportive housing services will develop clear, written tenant selection criteria, including eligibility and the ability to comply with the terms of the lease. Selection criteria will be uniformly and consistently applied to all applicants.

Because HIV and co-morbid disorders may result in a history of evictions or poor credit, it is expected that programs will strive to help clients become tenants who might otherwise be refused in the general rental market.

Denials may be due to ineligibility or for reasons that make a client unsuitable or unable to comply with lease terms, including:

- ◆ Poor credit history
- ◆ Previous evictions
- ◆ Incomplete or false application information
- ◆ Negative landlord references
- ◆ History of certain criminal convictions
- ◆ Inadequate income to cover rent

Applicants found to be ineligible or unable to comply with a lease agreement will be provided a written explanation why they were denied housing. This explanation will include contact names and phone numbers for appealing the rejection.

STANDARD	MEASURE
PHSPs will comply with relevant fair housing laws in selecting tenants for housing.	Program review and monitoring to confirm.
Providers will develop clear, written tenant selection criteria including eligibility and suitability. Selection criteria will be uniformly and consistently applied to all applicants.	Selection criteria on file at provider agency. Program review and monitoring to confirm consistency of application.
Ineligible or unsuitable applicants will be provided a denial explanation and contact names and phone numbers for appeal.	Program review and monitoring to confirm.

### INTAKE – PSHPS

Client intake is required for all clients who request or are referred to HIV permanent supportive housing services. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation.

During the intake process and throughout HIV permanent supportive housing service



delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information. (Specification should indicate the type of information that can be released).

As part of the intake process, the client file will include the following information (at minimum):

- ◆ Proof of HIV diagnosis
- ◆ Proof of income
- ◆ Proof of residence in Los Angeles County

**Required Forms:** Programs must develop the following forms in accordance with state and local guidelines.

Completed forms are required for each client:

- ◆ Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- ◆ Consent to Receive Services
- ◆ Limits of Confidentiality (Confidentiality Policy)
- ◆ Client Rights and Responsibilities
- ◆ Client Grievance Procedures

STANDARD	MEASURE
Intake process is begun during first contact with client.	Intake tool is completed and in client file.
Eligibility for services is determined.	Client's file includes: <ul style="list-style-type: none"> <li>• Proof of HIV diagnosis</li> <li>• Proof of income</li> <li>• Proof of Los Angeles County residence</li> </ul>
Confidentiality Policy, Release of Information and Consent to Receive Services is discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

### ASSESSMENT – PSHPS

An assessment serves as the basis for developing a needs and services plan and to ensure the quality of services provided. Initial assessments must be completed within 30 days of a client's admission to a permanent supportive housing program. Reassessments will be offered to residents on an as needed basis.

Assessments are developed collaboratively and signed by both the resident and staff member completing the assessment.

Assessment information should include (at minimum):

- ◆ Substance abuse history and current use
- ◆ ADL needs
- ◆ Spiritual/religious needs
- ◆ Social support system
- ◆ Legal issues
- ◆ Family issues

- ◆ Financial resources/insurance status
- ◆ Nutritional needs
- ◆ Harm reduction practices
- ◆ Mental health treatment history
- ◆ History of housing experiences
- ◆ Case management history and needs
- ◆ Needs and current services

STANDARD	MEASURE
Assessments will be completed within 30 days of client admission.	Assessment, signed by client and staff on file in client chart that includes: <ul style="list-style-type: none"> <li>• Substance use and history</li> <li>• ADL needs</li> <li>• Spiritual/religious needs</li> <li>• Social support system</li> <li>• Legal issues</li> <li>• Family issues</li> <li>• Financial/insurance status</li> <li>• Nutritional needs</li> <li>• Harm reduction practices</li> <li>• Mental health treatment history</li> <li>• History of housing experiences</li> <li>• Case management history and needs</li> <li>• Needs and current services.</li> </ul>
Reassessments will be offered to residents on an as-needed basis.	Reassessments on file in client chart.

## EDUCATION – PSHPS

Tenant education is a continuous process.

Upon intake, tenants should be offered information about the facility, policies and procedures and services to include (at minimum):

- ◆ Confidentiality
- ◆ Safety issues
- ◆ House rules and activities
- ◆ Client rights and responsibilities
- ◆ Grievance procedures
- ◆ Prevention
- ◆ Risk reduction practices
- ◆ Harm reduction
- ◆ Licit and illicit drug interactions
- ◆ Medical complications of substance abuse
- ◆ Hepatitis
- ◆ Health and self-care practices
- ◆ Referral information
- ◆ Pet-owner responsibilities
- ◆ Neighbor relations
- ◆ TB

To ensure the relevance of the information provided, tenants should be given ongoing opportunities to have input into the education planning process.

STANDARD	MEASURE
Tenants will be educated about facility, policies and procedures and services.	Education contacts recorded in client chart.

### CASE MANAGEMENT/SUPPORTIVE SERVICES – PSHPS

The goal of case management for PSHPs is to help clients increase independence and improve decision-making skills. Case management includes assessing needs, developing ISPs, advocacy, monitoring progress and coordinating services (especially when clients seek care from more than one provider). Permanent supportive housing programs must either provide comprehensive case management services on site, or link clients to appropriate services.

In addition, the following supportive services (as needed by the residents) must be made available either onsite or by referral:

- ◆ Substance abuse counseling and treatment
- ◆ Crisis counseling
- ◆ Mental health treatment
- ◆ Neighborhood orientation
- ◆ Money management
- ◆ Representative payee services
- ◆ Transportation
- ◆ Social and recreational activities
- ◆ Medical care
- ◆ Adult day care
- ◆ Legal services
- ◆ Budget counseling and training
- ◆ Benefits and public entitlements counseling and advocacy
- ◆ Child care
- ◆ Parenting skills classes
- ◆ Local school information
- ◆ HIV transmission risk assessment and prevention counseling
- ◆ Peer support
- ◆ Vocational training
- ◆ Education
- ◆ Treatment education
- ◆ Dental treatment
- ◆ Other social services

When the following services are not provided onsite, programs will demonstrate linkages with HIV primary and public health, mental health services, HIV case management services, and alcohol and drug counseling and/or treatment programs.

STANDARD	MEASURE
Programs must either provide comprehensive case management services onsite, or link clients with appropriate services.	Record of case management or linked referral on file in client file.
Individualized supportive services plans will be developed as needed.	Individualized supportive services plan on file in client file.
Programs will provide or make available by referral the full spectrum of HIV and housing related services.	Record of service provision or linked referrals on file in client file.

STANDARD	MEASURE
Programs will demonstrate linkages with the following services when not provided onsite: <ul style="list-style-type: none"> <li>• HIV primary and public health</li> <li>• Mental health</li> <li>• HIV case management</li> <li>• Substance abuse</li> </ul>	Memoranda of Understanding on file at provider agency.

### RESIDENCE MAINTENANCE – PSHPS

PSHPs will maintain or lease units that meet housing quality standards as outlined in 24 Code of Federal Regulations, Part 574.310(b) (see: <http://www.washingtonwatchdog.org/documents/cfr/title24/part574.html#574.310>) In the case of scattered site master leasing, at least two lease agreements will be made at each housing site.

Providers and/or landlords will monitor the performance of property management. Units will be maintained in safe and habitable conditions at all times.

Property managers will be educated about the medical effects of HIV and the importance of special maintenance considerations, including:

- ◆ Consistent heat and air conditioning
- ◆ Avoidance of physical hazards for those with impaired mobility
- ◆ Regular pest extermination

Maintenance problems related to heat or hot water should be treated as emergencies.

STANDARD	MEASURE
Permanent housing units will meet housing quality standards outlined in 24 Code of Federal Regulations, Part 574.310 (b).	Unit inspection and monitoring to confirm.

### POLICIES AND PROCEDURES MANUAL – PSHPS

HIV permanent supportive housing service providers must maintain a policies and procedures manual that covers the following issues (at minimum):

- ◆ Addressing drug and alcohol sale and use, including steps to deal with relapsing clients to ensure their ability to maintain housing
- ◆ Protecting privacy and confidentiality
- ◆ Ensuring safety and security, including violence to self and others
- ◆ Payment of rent by residents, including during hospitalization
- ◆ Grievance procedures
- ◆ Live-in caregivers
- ◆ Service animals
- ◆ Disaster plan

STANDARD	MEASURE
PSHPs must maintain policy and procedure manual.	<p>Policies and procedures manual on file at provider agency that addresses (at minimum):</p> <ul style="list-style-type: none"> <li>• Substance abuse and relapse</li> <li>• Privacy and confidentiality</li> <li>• Safety and security</li> <li>• Rent payment during hospitalization</li> <li>• Grievances</li> <li>• Live-in caregivers</li> <li>• Service animals</li> <li>• Disaster plan</li> </ul>

#### LANDLORD RELATIONSHIPS – PSHPs

PSHPs that provide scattered site master leasing services will act as liaison between the landlord and tenant, and will (at minimum)

- ◆ Prohibit landlord screening of potential tenants and strictly maintain the confidentiality of sub-lessees
- ◆ Negotiate tenant complaints and problems with the landlord and/or management company, including minor repairs, safety issues, etc.
- ◆ Provide cleaning, painting and light repair services to units at the time of change in sub-lessee
- ◆ Negotiate landlord complaints and problems with tenants

STANDARD	MEASURE
<p>Programs will act as liaison between landlord, management company and tenant including:</p> <ul style="list-style-type: none"> <li>• Prohibiting screening and maintaining confidentiality</li> <li>• Negotiate complaints and problems</li> <li>• Prepare units for new sub-lessees</li> <li>• Negotiate landlord complaints with tenants</li> </ul>	Program review, monitoring and inspection to confirm.

#### DISCHARGE PLANNING – PSHPs

When requested, discharge planning services will be provided to tenants that include (at minimum):

- ◆ Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate
- ◆ Linkage to supportive services that enhance access to care (e.g., case management, meals, transportation)
- ◆ Early intervention services to link people living with HIV into care, including outreach, HIV counseling and testing and referral
- ◆ Housing such as residential care, transitional housing, independent housing, etc.

STANDARD	MEASURE
<p>When requested, discharge planning services will be provided to tenants to include:</p> <ul style="list-style-type: none"> <li>• Linkage to primary medical care</li> <li>• Linkage to supportive services</li> <li>• Early intervention services</li> <li>• Housing services</li> </ul>	Discharge plan on file in client file

#### RESIDENT EVICTION – PSHPs

Permanent supportive housing providers are required to follow State laws and regulations

regarding eviction. Eviction can only be pursued if it can be verified that a resident has violated the lease.

Examples include:

- ◆ Non-payment of rent
- ◆ Disturbance of health, safety or welfare of others
- ◆ Damage to the premises
- ◆ Interference with management of the premises
- ◆ Repeated violations of the program agreement

Residents will be informed about the reason(s) they are being evicted. Due process will be followed. Under no circumstances will landlords or providers perform “self-help” evictions (e.g., turn-off power, change locks).

Providers will maintain information about emergency housing resources to which residents may be referred if they are required to leave the housing program. When possible, supportive services should be offered to residents making these transitions.

STANDARD	MEASURE
Evictions will follow state laws and regulations.	Program review and monitoring to confirm.
Programs will refer evicted residents to emergency housing.	Record of referrals on file in client chart.

## RESIDENT RECORDS – PSHPS

Providers of permanent supportive housing services will maintain the following confidential resident records:

- ◆ Income verification
- ◆ HIV diagnosis verification
- ◆ Assessment
- ◆ ISP
- ◆ Emergency contacts
- ◆ Medical information and contacts
- ◆ Case notes
- ◆ Program agreement (if applicable)
- ◆ Release of Information
- ◆ Discharge forms (if applicable)
- ◆ Signed grievance policy
- ◆ Signed Confidentiality Policy

STANDARD	MEASURE
Providers will maintain confidential resident records.	Resident records on file that include: <ul style="list-style-type: none"> <li>• Income verification</li> <li>• HIV diagnosis verification</li> <li>• Assessment</li> <li>• ISP</li> <li>• Emergency contacts</li> <li>• Medical information</li> <li>• Case notes</li> <li>• Program agreement</li> <li>• Release of Information</li> <li>• Discharge forms</li> <li>• Grievance policy</li> <li>• Confidentiality Policy</li> </ul>

## STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all residential care and housing staff will be able to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Residential care and housing staff will complete an agency-based orientation within seven days of being hired that includes client confidentiality and HIPAA regulations. In addition, all new staff must receive HIV/AIDS education within the first three months of employment. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

Direct care staff will be knowledgeable about the HIV disease process and the psychological effects of living with HIV, as well as the co-morbidities of substance abuse and mental illness and their effects on the management of HIV illness. All staff who provide direct-care services and who require licensure must be properly licensed by the state of California. Non-licensed or certified direct care staff will possess appropriate training, experience or certification.

Periodic staff training is required to ensure the continued delivery of quality services. Supervision is required of all staff to provide guidance and support. Direct care staff will be provided with a minimum of one hour's client care-related supervision per month.

STANDARD	MEASURE
Residential care and housing staff will be able to provide linguistically and culturally age-appropriate care and complete documentation as required by their positions.	Resumes and record of training in employee file to verify.
Staff will receive an agency orientation (including HIPAA and confidentiality) within seven days, and HIV training within three months of employment.	Record of orientation and training in employee file.
All direct-care staff who require licensure or certification must be licensed by the State of California or certified by their respective professional organizations.	Copies of licenses and certifications on file at provider agency.
Periodic staff training is required.	Record of staff trainings on file at provider agency.
Direct care staff will be provided one hour's client care-related supervision per month.	Record of supervision on file at provider agency.

## RESIDENTIAL CARE PROGRAMS

### TRANSITIONAL RESIDENTIAL CARE FACILITIES (TRCF)

TRCF must have qualified staff to manage the facility, supervise operations on a 24-hour basis, and maintain records as required by the funder. Further, all staff should be trained on HIV-related and confidentiality issues. For licensed facilities operating an adult residential facility, a community care facility, or a congregate living health facility that offers residential transitional housing, staffing requirements are established in regulations describing those services. For programs that do not fall into these licensure categories but provide transitional housing services, the staffing requirements include, but are not limited to the following.

#### **DIRECT CARE STAFF**

The facility will ensure that all direct services to clients are provided by staff trained in the provision of the facility services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.



For daytime support, direct care staff must include:

- ◆ Employee(s) designated to perform admission, intake and assessment functions, including ongoing evaluation of the residents' supervision and care needs
- ◆ An employee responsible for oversight and provision of planned activities, including oversight of volunteers. For facilities with a licensed capacity of 16 to 49 clients, the persons responsible for planned activities may have other responsibilities; for facilities with licensed capacity of 50 or more clients, the designated activities employee must be full time.

For night supervision from 4:00 p.m. to 8:00 a.m., direct care staff must include:

- ◆ Facilities housing 15 or fewer clients - one staff person on call and on the premises
- ◆ Facilities housing 16 to 100 clients - one staff person on duty, awake and on the premises
- ◆ Facilities housing 101 to 200 clients - at least one staff person on duty, on the premises and awake, and at least one staff person on-call, on the premises and another person on-call and capable of responding within 30 minutes
- ◆ Facilities housing seven or more clients who rely upon others to perform all ADL - at least one person on duty, on the premises, and awake at night; for every additional 14 clients - one additional person on duty, on the premises, and awake at night
- ◆ All overnight housing staff must be trained in CPR, agency emergency protocols, and conflict management

#### **ADMINISTRATIVE AND SUPPORT STAFF**

An administrative employee has primary responsibility for the facility. The provider will operate continuously with at least a house manager and the necessary staff for the delivery of required services.

#### **TB CONTROL**

The provider will adhere to Exhibit C, "Tuberculosis Exposure Control Plan for Residential Facilities" as provided by the Los Angeles County Department of Public Health Tuberculosis Control Program.

#### **ANNUAL TB SCREENING FOR STAFF**

Prior to employment or service provision and annually thereafter, the provider will obtain and maintain documentation of TB screening for each employee, volunteer and consultant providing services. Such TB screening will consist of a tuberculin skin test (Mantoux test) and/or written certification by a physician that the person is free from active TB based on a chest X-ray. The provider will adhere to the attached "Guidelines for Staff Tuberculosis Screening."

STANDARD	MEASURE
TRCFs will maintain the following administrative and support staff (at minimum): <ul style="list-style-type: none"> <li>• Employee with primary responsibility for the facility</li> <li>• House manager</li> <li>• Daytime and nighttime direct care staff</li> </ul>	Staff plan and program review and monitoring to confirm.
Daytime staff must include one for admission, intake and assessment and one for oversight and provision of planning activities. For 16–49 clients, staff for planned activities may have other responsibilities. For 50 or more clients, must have full time staff for planned activities.	Staff plan and program review and monitoring to confirm.

STANDARD	MEASURE
Nighttime direct staff must include one on call and on the premises for up to 15 clients; one on duty, awake and on the premises for 16–100 clients; one on duty, on the premises and awake and one on-call, on the premises and one on-call and capable of responding within 30 minutes for 101–200 clients.	Record of service provision or linked referrals on file in client file.
For seven or more residents who require staff assistance to perform all ADL, one person on duty, on the premises and awake and for every additional 14 clients, one additional person on duty, on the premises and awake. All overnight staff must be trained in CPR, agency emergency protocols and conflict management.	Staff plan and program review and monitoring to confirm.
Prior to employment and annually, provider must obtain and maintain documentation of TB screening for each employee, volunteer and consultant providing services.	Staff plan and program review and monitoring to confirm.

### RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI)

The RCFCI must have the staff qualified to manage the facility, supervise operations on a 24-hour basis as necessary, and maintain records as required by the funder. Further, all staff should be trained on HIV-related and confidentiality issues.

#### **DIRECT CARE STAFF**

The facility will ensure that all direct services to residents are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. An RN case manager must be responsible for the provision and/or coordination of the services, specified in the ISP.

- ◆ At least one direct care staff person must be on duty whenever residents are present.
- ◆ For daytime hours, the minimum staffing ratio should be one direct care staff person up, awake, and on duty for every 10 residents on the premises.
- ◆ For evening and night hours, the minimum staffing is one direct care staff person up, awake, and on duty for every 15 residents on the premises.
- ◆ For evening and night hours, at least one direct care staff person must be on call within 30 minutes of the facility in case of an emergency.
- ◆ For residents who are unable to assist in the performance of ADL and for residents whose death is imminent, the direct care staffing ratio should be one direct care staff person to every three residents.

#### **ADMINISTRATIVE AND SUPPORT STAFF**

The following staff is required:

- ◆ A certified administrator appointed by the licensee (unless exempt from licensure).
- ◆ An employee designated by the administrator, with primary responsibility for the residential care facility for the chronically ill..
- ◆ Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds

#### **STAFFING DEFINITIONS**

Provider's personnel, including consultants and any subcontractor's staff, will meet the minimum requirements established for each discipline as described in the definition section of this document.

**ORIENTATION AND STAFF IN-SERVICE TRAINING**

The provider will institute and maintain an in-service training program for its personnel and volunteers. Such training will include an orientation to all applicable policies and procedures for RCFCI services. Such training will also include, but not be limited to, HIV/AIDS-related issues and service approaches, approved infectious waste disposal procedures, universal precautions for infection control, recognition of early signs of illness and the need for professional assistance, and other topics which are essential to providing quality care. Within three months after employment, all direct care staff will have at least 20 hours of on-the-job training on HIV/AIDS related conditions.

**ANNUAL TB SCREENING FOR STAFF**

Prior to employment or service provision and annually thereafter, the provider will obtain and maintain documentation of TB screening for each employee, volunteer and consultant providing services. Such TB screening will consist of tuberculin skin test (Mantoux test) and/or written certification by a physician that the person is free from active TB based on a chest X-ray.

STANDARD	MEASURE
RCFCIs will maintain the following administrative and support staff (at minimum): <ul style="list-style-type: none"> <li>• Administrator</li> <li>• Employee with primary responsibility for the facility</li> <li>• Support staff to perform miscellaneous activities</li> <li>• Direct care staff</li> </ul>	Staff plan and program review and monitoring to confirm.
An RN case manager will be responsible for provision and/or coordination of services.	Staff plan and program review and monitoring to confirm.
Daytime direct staff ratio will be one awake/on duty staff to 10 residents.	Record of service provision or linked referrals on file in client file.
Nighttime direct staff ratio will be one awake/on duty staff to 15 residents; at least one direct staff on call within 30 minutes of the facility. For residents who require staff assistance to perform all ADL living or for whom death is imminent, the ratio of direct care staff to residents can be no more than 3:1.	Staff plan and program review and monitoring to confirm.
Provider must institute and maintain in-service training for staff and volunteers. Within 3 months of hire, all direct care staff must have at least 20 hours of on-the-job training on HIV/AIDS-related conditions.	Staff plan and program review and monitoring to confirm.
Prior to employment and annually, provider must obtain and maintain documentation of TB screening for each employee, volunteer and consultant providing services.	Staff plan and program review and monitoring to confirm.

**HOUSING SERVICES****EMERGENCY SHELTER PROGRAMS (ESPS)**

ESPs must hire staff qualified to manage the facility, supervise operations on a 24-hour basis and maintain required records. At minimum, the following staff should be hired:

**ADMINISTRATIVE AND SUPPORT STAFF**

- ◆ Employee with primary responsibility for the facility
- ◆ Support staff to perform office work, cooking, house cleaning, laundering and maintenance activities

### ***DIRECT CARE STAFF***

Programs will ensure that all direct service staff are appropriately trained and that all services requiring specialized skills are performed by licensed or certified personnel. A staff member trained in CPR will be on duty at all times.

Daytime direct care staff must include (at minimum):

- ◆ Employee(s) designated to perform admission, intake, assessment and ongoing evaluation of clients' treatment and care needs

Nighttime (between 10:00 pm and 7:00 am) direct care staff must include (at minimum):

- ◆ Facilities housing 15 or fewer clients – one staff person on call and on the premises.
- ◆ Facilities housing 16 to 100 clients – one staff person on duty, awake and on the premises.
- ◆ Facilities housing 101 to 200 clients – at least one staff person on duty, on the premises and awake, and at least one staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes.

STANDARD	MEASURE
ESPs will maintain the following administrative and support staff (at minimum): <ul style="list-style-type: none"> <li>Employee with primary responsibility for the facility</li> <li>Support staff to perform miscellaneous activities</li> </ul>	Staff plan and program review and monitoring to confirm.
ESPs will maintain the following daytime direct care staff (at minimum): <ul style="list-style-type: none"> <li>Employee(s) designated to perform admission, intake, assessment and evaluation</li> </ul> A staff member trained in CPR will be on duty at all times.	Staff plan and program review and monitoring to confirm.
ESPs will maintain the following nighttime direct care staff (at minimum): <ul style="list-style-type: none"> <li>15 or fewer clients – one staff person on call and on the premises</li> <li>16 to 100 clients – one staff person on duty, awake and on the premises</li> <li>101 to 200 clients – at least one staff person on duty, on the premises and awake, and at least one staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes</li> </ul>	Staff plan and program review and monitoring to confirm.

### **TRANSITIONAL HOUSING PROGRAMS (THPS)**

THPs must hire staff qualified to manage the facility, supervise operations on a 24-hour basis and maintain required records. At minimum, the following staff should be hired:

#### ***ADMINISTRATIVE AND SUPPORT STAFF***

- ◆ Employee with primary responsibility for the facility
- ◆ Support staff to perform office work, cooking, house cleaning, laundering and maintenance activities

#### ***DIRECT CARE STAFF***

Programs will ensure that all direct service staff are appropriately trained and that all services requiring specialized skills are performed by licensed or certified personnel. A staff member trained in CPR will be on duty at all time.

Daytime direct care staff must include (at minimum):

- ◆ Employee(s) designated to perform admission, intake, assessment and ongoing evaluation of clients' treatment and care needs

Nighttime (between 10:00 pm and 7:00 am) direct care staff must include (at minimum):

- ◆ Facilities housing 15 or fewer clients – one staff person on call and on the premises
- ◆ Facilities housing 16 to 100 clients – one staff person on duty, awake and on the premises
- ◆ Facilities housing 101 to 200 clients – at least one staff person on duty, on the premises and awake, and at least one staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes

STANDARD	MEASURE
<ul style="list-style-type: none"> <li>THPs will maintain the following administrative and support staff (at minimum): <ul style="list-style-type: none"> <li>Employee with primary responsibility for the facility</li> <li>Support staff to perform clerical and housekeeping activities</li> </ul> </li> </ul>	Staff plan and program review and monitoring to confirm.
THPs will maintain the following daytime direct care staff (at minimum): <ul style="list-style-type: none"> <li>Employee(s) designated to perform admission, intake, assessment and evaluation</li> <li>A staff member trained in CPR will be on duty at all times.</li> </ul>	Staff plan and program review and monitoring to confirm.
THPs will maintain the following nighttime direct care staff (at minimum): <ul style="list-style-type: none"> <li>15 or fewer clients – one staff person on call and on the premises</li> <li>16 to 100 clients – one staff person on duty, awake and on the premises</li> <li>101 to 200 clients – at least one staff person on duty, on the premises and awake, and at least one staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes</li> </ul>	Staff plan and program review and monitoring to confirm.

## PERMANENT SUPPORTIVE HOUSING PROGRAMS (PSHPS)

### GENERAL HOUSING STAFF

PSHPs may hire, train and maintain general housing staff, including custodians, security and maintenance staff. Onsite or on-call residential management, security staff and/or emergency supportive services staff will be available to residents at all times.

STANDARD	MEASURE
Programs will hire, train and maintain general housing staff	Program review and monitoring to confirm.
Resident managers, security and emergency supportive services staff will be available at all times	Program review and monitoring to confirm.

### SUPPORTIVE SERVICES STAFF

Programs providing permanent housing with supportive services will have in place staff to complete the following functions:

- ◆ Supervising all supportive services staff and activities
- ◆ Client care-related supervision
- ◆ Bolstering program services offered
- ◆ Hiring, training and supervising staff
- ◆ Physical plant management
- ◆ Coordinating outside nursing care
- ◆ Implementing and evaluating State and county contract guidelines

- ◆ Daily operations of the agency
- ◆ Resident intake/assessment
- ◆ Linkages to outside social and health services providers, education and therapeutic programs
- ◆ Assessment and resolution of crisis situations
- ◆ Provision of, or referral to, employment services, education programs/workshops and addiction assistance

Programs providing permanent housing with supportive services require the following staff:

- ◆ Chief Operations Officer
- ◆ Director of Resident Services
- ◆ Resident Services Coordinator

STANDARD	MEASURE
Programs providing permanent supportive housing require the following staff (at minimum): <ul style="list-style-type: none"> <li>• Chief Operations Officer</li> <li>• Director of Resident Services</li> <li>• Resident Services Coordinator</li> </ul>	Program review and monitoring to confirm.

#### **SCATTERED-SITE MASTER LEASING STAFF**

Programs providing scattered-site master leasing housing services will have in place staff to complete the following functions:

- ◆ Hiring, training and supervising staff
- ◆ Client care-related supervision
- ◆ Physical plant management
- ◆ Coordinating outside nursing care
- ◆ Implementing and evaluating State and county contract guidelines
- ◆ Daily operations of the agency
- ◆ Completing reports
- ◆ Performing investigations to ensure accuracy of housing applications
- ◆ Negotiating leases and contracts for properties
- ◆ Auditing, contract monitoring and program adherence
- ◆ Fiscal and administrative support

Master site leasing housing services require the following staff:

- ◆ Chief Operations Officer
- ◆ Master Leasing Coordinator
- ◆ Senior Accountant

STANDARD	MEASURE
Programs providing scattered-site master leasing require the following staff (at minimum): <ul style="list-style-type: none"> <li>• Chief Operations Officer</li> <li>• Senior Accountant</li> <li>• Master Leasing Coordinator</li> </ul>	Program review and monitoring to confirm.

## UNITS OF SERVICE

### RESIDENTIAL CARE PROGRAMS

- ◆ Transitional residential care facility units: calculated in number of days in transitional residential care facility
- ◆ Residential care facility for the chronically ill units: calculated in number of days in residential care facility for the chronically ill

### EMERGENCY SHELTER AND TRANSITIONAL HOUSING PROGRAMS

**Unit of service:** Units of service (defined as reimbursement for residential services) are based on specific residential services provided to eligible clients.

- ◆ **Hotel/motel and meal voucher units:** calculated in the number of voucher days provided
- ◆ **Emergency shelter units:** calculated in number of days in emergency shelter
- ◆ **Transitional housing units:** calculated in number of days in transitional housing
- ◆ **Case management service units:** calculated in number of case management encounters or referrals to case management services
- ◆ **Substance abuse service units:** calculated in number of substance abuse treatment encounters or referrals to substance abuse services
- ◆ **Mental health service units:** calculated in number of mental health service encounters or referrals to mental health services

**Number of clients:** Client numbers are documented using the figures for unduplicated clients within a given contract period.

### PERMANENT SUPPORTIVE HOUSING PROGRAM

**Unit of service:** Units of service (defined as reimbursement for housing services) are based on specific housing services provided to eligible clients.

- ◆ **Permanent supportive housing units:** calculated in the number of permanent supportive housing units populated by unduplicated clients
- ◆ **Case management service units:** calculated in number of case management encounters or referrals to case management services
- ◆ **Substance abuse service units:** calculated in number of substance abuse treatment encounters or referrals to substance abuse services
- ◆ **Mental health service units:** calculated in number of mental health service encounters or referrals to mental health services

**Number of clients:** Client numbers are documented using the figures for unduplicated clients within a given contract period.

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## ACRONYMS

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ADL	Activities of Daily Living
AIDS	Acquired Immune Deficiency Syndrome
CCA	Central Coordinating Agency
DHSP	Division of HIV and STD Programs
ESP	Emergency Shelter Program
GAF	Global Assessment of Functioning
HAART	Highly Active Antiretroviral Therapy
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HUD	Housing and Urban Development
ILS	Independent Living Skills
ISP	Individual Services Plan
LVN	Licensed Vocational Nurse
MD	Medical Doctor
MSW	Masters of Social Work
PLWH	People Living with HIV/AIDS
PSHP	Permanent Supportive Housing Programs
RCFCI	Residential Care Facility for the Chronically Ill
RCS	Residential Care Services
RN	Registered Nurse
SSI	Supplemental Security Income
SSP	State Supplemental Program
STD	Sexually Transmitted Disease
TB	Tuberculosis
THP	Transitional Living Program
TRCF	Transitional Residential Care Facility